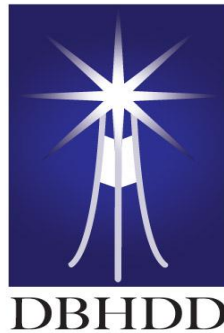


Georgia Department of Behavioral Health & Developmental Disabilities



2013 INTERIM QUALITY MANAGEMENT REPORT

Prepared by the DBHDD Office of Quality Management
August 2013

Contents

Introduction.....	3
Activities of the Quality Councils.....	3
Executive Quality Council.....	3
Hospital System Program Quality Council.....	4
Community Behavioral Health Program Quality Council.....	4
Developmental Disabilities Program Quality Council	5
Status of Quality Management Work Plan Goals	6
DBHDD QM Work Plan.....	6
Hospital System QM Work Plan.....	6
CBH QM Work Plan.....	7
DD QM Work Plan	7
Key Performance Indicators and Outcomes	7
Data Collection Plan/Data Definition Document	7
Dashboards.....	7
Hospital System Key Performance Indicators	8
Community Behavioral Health Program Key Performance Indicators	8
Developmental Disability Programs Key Performance Indicators	11
Person Centered Supports	11
Quality Monitoring Activities.....	15
Complaints and Grievances	15
Hospital and Community Incident Data December 2012 – May 2013.....	16
Hospital Peer Review and Credentialing	18
Hospital Utilization Review.....	18
Adult Mental Health Fidelity Reviews	18
QM Audits: Quality Service Reviews of Adult Behavioral Health Community Providers .	19
Child and Adolescent Community Mental Health Programs (CAMH).....	21
Mental Health Coalition Meetings.....	21
Behavioral Health Contracted External Review Organization (ERO)	22
Implementation and Results of Best Practice Guidelines:	24
DD Reviews of Individuals Served.....	28
DD QM Reviews of Providers.....	30
DD Transition Quality Reviews.....	31
DBHDD Quality Management Training Program	32

Data Reliability Process	32
Hospital System KPI Data Integrity	32
Community BH Key Performance Indicator Data Integrity	33
DD KPI Data Integrity	33
Summary	33
Appendix A Community Behavioral Health Outcomes Framework	34
Appendix B DBHDD Quality Management Work Plan.....	35
Appendix C Hospital System Quality Management Work Plan.....	38
Appendix D Community Behavioral Health Quality Management Work Plan	41
Appendix E Developmental Disabilities Quality Management Work Plan.....	43
Appendix F Hospital System KPI Dashboards	48
Appendix G CBH System KPI Dashboards.....	52
Appendix H Developmental Disabilities KPI Dashboards	72
Appendix I Cognitive Therapy – Dr. Aaron T Beck	80
Appendix J Suicide Prevention.....	82

Introduction

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) serves as the single state authority that provides direct services, administration, and monitoring of all facets of the state publicly funded behavioral health & developmental disabilities system. DBHDD's role as a direct service provider is limited to the operation of six state hospital campuses. Outpatient services are delivered by a network of private and public providers with whom DBHDD contracts. DBHDD Contractors are community-based organizations which administer behavioral health & developmental disabilities services throughout the state and are responsible for the provision of comprehensive services for children and adults with substance abuse disorders, serious and persistent mental illness (SPMI) and developmental disabilities.

The DBHDD quality management program was formally established in 2011 in response to the Department's commitment to the continuous improvement of the quality of its services. The Department's quality management plan was developed and implemented in December 2011 and was updated in June of 2012 and April of 2013. This plan established guidelines for the structure of a DBHDD system-wide quality management program encompassing hospital and community based services.

This is the August 2013 Interim Quality Management (QM) Report of the DBHDD. The report and the summary of activities contained in this comprise a six month review of quality management activities that have taken place in the hospital, community behavioral health and developmental disabilities systems of care, as well as a review of QM activities at the State Office. It is the intent of DBHDD to share this report with Department staff and stakeholders.

The primary purpose of this Interim Report is to synthesize and communicate the DBHDD QM activities taking place across the Department. As a result of data availability, the analysis and discussion contained within this report will vary, but generally focuses on activities between January 2013 – June 2013.

Activities of the Quality Councils

Executive Quality Council

The Executive Quality Council (EQC) meets six times per year and acts as the governing body for the QM program providing strategic direction and is the ultimate authority for the scope of DBHDD QM activities including the QM plan, the DBHDD work plan and the annual evaluation. The EQC is the highest-level quality committee in DBHDD. The EQC met every other month from December 2012 – June 2013 for a total of three meetings.

During those meetings the EQC:

- Performed its annual review of the QM system including a review of the QM structure.
- Revised the membership of the Executive Quality Council and reviewed changes to the membership of the Community Behavioral Health (CBH) and Developmental Disabilities (DD) Program Quality Councils (PQC).
- Approved the April 2013 revision of the DBHDD QM Plan.

- Discussed the feasibility of setting DBHDD wide key performance indicators.
- Received a QM presentation by the Georgia Association of Community Service Boards (CSBs).
- Discussed information that should be reported to the EQC.
- Received updates from the Hospital, CBH and DD PQC's regarding the quality management-related work that each functional area is prioritizing and reviewed trends/patterns from their KPIs.
- Prioritized the transition of quality placements for DD consumers transitioning from institutions to the community and received an update regarding the new RQR team process that was being implemented by the DD service system.
- Prioritized the development of a DBHDD Enterprise Data Warehouse.
- Prioritized the development of a review committee, whose goal is to review and recommend changes to the community incident management and investigations process.
- Prioritized receipt of dental services for DD consumers.

Hospital System Program Quality Council

The Hospital System PQC meets quarterly, and has held two meetings between December 2012 and June 2013. In addition to those quarterly meetings, the Hospital System held monthly Hospital System-wide quality management meetings to monitor and address patient safety performance measures. During those meetings this PQC:

- Reviewed PI initiatives focused on management of aggression, restraint and seclusion, polypharmacy, consumer satisfaction and other performance measures.
- Reviewed and modified strategies being utilized by hospital-based PI teams to improve patient safety.
- Addressed data collection methodologies and data integrity issues that affected reporting timeliness and quality.
- Reviewed and discussed the Triggers and Thresholds report data, the hospital system dashboard measures and specific hospital system KPI trends and patterns and made suggestions/recommendations for program/service changes.

Community Behavioral Health Program Quality Council

The Community Behavioral Health PQC meets monthly and has held seven meetings between December 2012 and June 2013. During those meetings the CBH PQC:

- Revised the membership of the Community Behavioral Health Program Quality Council.
- Reviewed community-based data available from the Office of Incident Management and Investigations, selected five measures to monitor and is continuing to work with that Office to analyze and refine standardized community-based incident trend reports.
- Reviewed and discussed the results, trends and/or patterns of the CBH KPIs and as a result of those reviews:
 - modified some of the target thresholds
 - determined additional KPIs needed to be developed and some of the current KPIs required revision
 - made suggestions/recommendations for program/service changes
- Developed a CBH Outcomes framework - see Appendix A.

- Discussed and selected additional KPIs that provide indicators of system-wide performance.
- Received an update/overview of the Child and Adolescent program's quality management system.
- Received periodic updates regarding the findings of the Fidelity reviews (SE & ACT)
- Received an update regarding the progress of the Suicide Prevention Program.
- Participated in a QM brainstorming session with multiple Community Service Board (CSB) representatives in May 2013 in order to obtain stakeholder input.
- Has developed a collaborative relationship with the Georgia Association of Community Service Boards (GACSB) and scheduled a series of conference calls between a subgroup of the CBH PQC and the Chair of the Benchmarking subgroup for the GACSB in order to obtain stakeholder input. As of the date of this report conference calls were held in June and July.
- Reinforced the importance of whole health and reviewed a list of suggested KPI physical health status indicators. Placed the issue of collecting physical health indicators on hold pending the outcome of the Department's ASO discussions.

Developmental Disabilities Program Quality Council

The Developmental Disabilities PQC meets quarterly and has held two meetings between December 2012 and June 2013. During those meetings the DD PQC:

- Reviewed the 2010 - 2011 NCI performance indicator data of consumers who have had a routine dental exam in the past year, and noted that Georgia scored significantly lower than the NCI average. As a result of the high prioritization by the EQC, a performance improvement project between the Division of Developmental Disabilities and the Georgia Department of Public Health was discussed. As an interim measure, the dental clinics at all DBHDD state hospitals will remain open and available to individuals with DD who are supported by DBHDD.
- Implemented a project to evaluate the current DD quality management system; components of the evaluation include:
 - Document reviews;
 - Assessment of "as is" status of the system;
 - Facilitation of a workgroup to design the "to be" quality system;
 - Design of preliminary and extended training necessary to implement the new system;
 - Development of a comprehensive manual for the implementation of a Comprehensive Quality System for Georgia's Developmental Disability System.
- Monitored the status of Quality Management Work Plan Goals.
- Reviewed ADA transition process and data in order to improve the quality of transitions to from State Hospitals to the Community.
- Reviewed the ongoing work of the DD Advisory Council which included quality improvement efforts in the DD system structure, system performance, and customer focus.
- Set program priorities for the Department's RFP for an Administrative Service Organization

- The Statewide Quality Improvement Council focused on re-defining their role in the State system. The State QI Council met on March 12, 2013, to review the supported employment project and make final adjustments for the version to be vetted through the DD Advisory Council. The Statewide QI Council will focus on the system redesign of the DD quality management system.

Status of Quality Management Work Plan Goals

Each Program Quality Council developed a work plan to guide the quality management activities within its area of responsibility. The EQC defines the work plan for the Department through the DBHDD QM Work Plan and then the Program Quality Councils develop program-specific work plans for the hospital system, the community behavioral health and developmental disabilities service delivery systems.

Below are descriptions of the status of each functional areas work plan and the progress toward achieving the work plan goals for each Quality Council:

DBHDD QM Work Plan

The DBHDD QM Work Plan (see Appendix B) outlines the key quality-related work prioritized by the Department. The first task of the first goal related to developing accurate, effective and meaningful performance measures was met via the development of KPI selection criteria which are in a data definition/data collection plan document. Additionally, the criteria have been put into electronic format for ease of use. The assessment of current PI measures for value and applicability is slightly behind schedule with a new anticipated target completion date of August 2013. The target date for the DD PI measures is subject to a comprehensive DD QM review currently being performed by an outside contractor and the anticipated completion date is December 2013.

The second goal's first task related to modifying the QM Training Plan to include all the functional areas is in-process but its completion has been delayed until September 2013 due to competing priorities.

The first task of the third goal related to the development of an CBH outcomes frames work is slightly behind schedule. A draft Community BH Outcomes framework has been developed and once it is finalized its applicability to all DBHDD QM functional areas will be assessed.

The fourth goal related to IT data systems is progressing. QM staff are currently in discussions with DBHDD IT staff to discuss data management needs.

The following are summaries of the activities related to each PQC's QM work plan which support the goals of the DBHDD's QM Work Plan.

Hospital System QM Work Plan

The Hospital System QM Work Plan (see Appendix C) represents a high level set of goals focused on the Quality Management infrastructure needed to maintain an effective quality management system. The overarching purpose of these goals is to refine the quality

management system so that there is greater consistency, accuracy, data integrity and accountability. These goals reflect the Hospital System's dedication to developing and maintaining the capacity to improve quality and do so efficiently, effectively, and in a way that maximizes the utilization of its resources.

The Hospital System is working to maintain and improve quality as it assists in DBHDDs strategic direction toward building community-based services while reducing its dependence on state hospitals. As the System's hospitals are reduced in size, closed and/or repurposed, it is essential that an effective quality management system is maintained so that those transitions are managed in a way that assures the consumers receive the quality of service that they deserve. At the time of this report, the progress, with regard to the identified goals was consistent with the plan.

CBH QM Work Plan

The Community BH work plan was discussed at the July 2013 PQC meeting and is currently in draft form. Even though the work plan is still in draft form, the first task of the first goal related to distribution of the PMET to the CBH membership has been met. The first task of the second goal related to QM training for CBH State and Regional Office staff has begun with the distribution of a memo outlining expectations related to the first QM web based training module. The progress towards the remainder of the goals is consistent with the plan. See appendix D for the CBH QM Work Plan.

DD QM Work Plan

The Developmental Disabilities system quality management work plan supports the DBHDD QM work plan and addresses the need to ensure that individual with DD who transition out of state hospitals receive the highest quality of services and achieve their goals once in the community. Progress toward meeting the goals of the DD work plan is consistent with the plan's targeted timelines. See Appendix E.

Key Performance Indicators and Outcomes

Data Collection Plan/Data Definition Document

A DBHDD data definition document was developed for the KPIs, for use by each of the three functional QM areas within the Department. The data definition document provides guidance on how each element and attribute should be used. It gives details about the structure of the elements and format of the data. Additionally this document was used as the basis to develop a tool (called the Performance Measure Evaluation Tool) which provides guidance on developing new and evaluating existing KPIs.

Dashboards

The KPI dashboard format was redesigned to incorporate the KPI data in table and graph form, measure definition & explanation, numerator & denominator explanation and an analysis of the KPI for the time period. The KPI dashboards can be found in Appendices F, G and H.

Hospital System Key Performance Indicators

The key performance indicators utilized by the Hospital System are a combination of quality measures that support the System's value of three priority areas:

1. The use of consumer feedback to reflect the quality of our services
 - a. Client Perception of Outcome of Care
 - i. Summary comments and analysis: The DBHDD Hospital System facilities have consistently scored higher than the baseline established on the basis of the national averages for the same survey tool. The Quality Management departments are looking at ways to improve the consistency and timeliness of reporting and the consistency and quality of the methods of administration of the survey instruments.
 - b. Client Perception of Empowerment
 - i. Summary comments and analysis: The DBHDD Hospital System facilities have consistently scored higher than the baseline established on the basis of the national averages for the same survey tool. The Quality Management departments are looking at ways to improve the consistency and timeliness of reporting and the consistency and quality of the methods of administration of the survey instruments.
2. The importance of continuity of care with regard to the transition of consumers between hospital and community services
 - a. Continuing Care Plan Created (Overall)
 - i. Summary comments and analysis: Issues that led to the decline reflected in December 2012's 94% (which was just below the lower target of 94.4%) were identified and corrected in January 2013. The result is represented in this quarter's (January-March) reporting of compliance which was steadily increasing for all three months. At the time of this report, the data for the quarter April-June were not complete and therefore not available.
3. The importance of supporting the recovery of individuals receiving hospital services.
 - a. Individual Recovery Plan Audit - Quality Measure
 - i. Summary comments and analysis: A gradual overall trend upwards (positive) is being achieved, even though the timeframe of January-March appears to be relatively flat. It appears the training and emphasis placed on the measure had an overall positive effect on the averages. The gradual improvements reflected in these data indicate that the current strategy has been effective. The hospital system will continue to work for additional improvements in this area.

The Hospital System plans to continue to monitor and improve the quality of care measured by these KPIs. The hospital system dashboard can be found in Appendix F.

Community Behavioral Health Program Key Performance Indicators

Summary and Recommendations for the current CBH KPIs:

1. Georgia Housing Voucher Program adult MH individuals in stable housing
 - Summary comments and analysis: The number of individuals receiving Georgia Housing Vouchers who are in stable housing has significantly exceeded the HUD standard of six months and DBHDDs target of 77% for the December 2012 –

June 2013 time period, and appears to be stable at about 90%. Further analysis over a broader time period is needed in order to pose a hypothesis of this stability measures success.

2. Georgia Housing Voucher Program adult MH individuals who left stable housing under unfavorable circumstances and have been reengaged and reassigned vouchers
 - Summary Comments and analysis: DBDD has several months tracking Georgia Housing Voucher individuals who left stable housing under unfavorable circumstance and were reengaged in services and a floor has been established (approximately 17%) to base future efforts at the provider level. This KPI will continue to be monitored.
3. Adult Mental Health supported employment providers that met a caseload average of employment specialist staff to consumer (ratio 20:1)
 - Summary Comments and analysis: The caseload average percent slowly increased between December 2012 and March 2013 as providers accommodated the July 1, 2012 funding increase. It is hypothesized that the April 2013 decline is due to an increase in funding. This indicator will continue to be monitored.
4. Individuals who had a first contact with a competitive employer within 30 days of enrollment
 - Summary Comments and analysis: This is an unduplicated KPI which is measured quarterly and overall the target of 50% is being met. This indicator will continue to be monitored going forward but the target will be increase to 75%.
5. Assertive Community Treatment consumers who are enrolled within 3 days of referral
 - Summary Comments and analysis: The target of 70% was met during the month of February but the data displayed varying percentages. As ACT providers indicated that there were different definitions of the term “enrollment” this KPI will be changed and a new one started in July 2013 which more clearly defines the intent of what needs to be measured.
6. Assertive Community Treatment consumers admitted to a Psychiatric Hospital within the past month
 - Summary Comments and analysis: The data shows a slight upward trend in utilization. The target of 7% or less was not met during this reporting period and providers indicated individuals were being admitted into hospitals for further stabilization.
7. Average number of jail/prison days utilized per enrolled Assertive Community Treatment consumer
 - Summary Comments and analysis: Overall the target of 1 day or less was met for this reporting period.
8. Intensive Case Management consumers with a Psychiatric Inpatient Admission within the past month
 - Summary Comments and analysis: Overall the target of 10% or less was met for this reporting period. Starting July 2013 the target for this KPI will be decreased to 5%.
9. Intensive Case Management consumers housed (non Homeless) within the past month
 - Summary Comments and analysis: Overall the target of 90% or more was met during this reporting period.

10. Average number of jail/prison days utilized per enrolled Intensive Case Management consumer
 - Summary Comments and analysis: Overall the target of .50 days or less was met for this reporting period. Starting July 2013 the target for this KPI will be decreased to 0.250 days or less.
11. Community Support Teams with a Psychiatric Inpatient Admission within the past month
 - Summary Comments and analysis: Overall the target of 10% or less was met during this reporting period.
12. Community Support Team consumers housed (non homeless) within the past month
 - Summary Comments and analysis: Overall the target of 90% or more was met during this reporting period.
13. Average number of jail/prison days utilized per enrolled Community Support Team consumer
 - Summary Comments and analysis: Overall the target of .75 days or less was met during this reporting period. The target for this measure will decrease to .250 days starting July 2013.
14. Case Management consumers with a Psychiatric Inpatient admission within the past month
 - Summary Comments and analysis: Overall the target of 10% or less was met during this reporting period. The target for this measure will decrease to 5% starting July 2013.
15. Case Management consumers housed (non homeless) within the past month
 - Summary Comments and analysis: Overall the target of 90% or more was met during this reporting period.
16. Average number of jail/prison days utilized per enrolled Case Management consumer
 - Summary Comments and analysis: Overall there was some variability in the average number of jail/prison days utilized during this time period which the providers attributed to a small number of individuals with longer incarcerations.
17. Adult Addictive Disease consumers who abstain from use or experience a reduction in use while in treatment
 - Summary Comments and analysis: Data collection for this annual KPI has been place for several years with the target of 40% being met for the 2012 year. Although a NOM (National Outcome Measure) indicator for block grants, a more specific KPI has been proposed going forward. This KPI will be replaced with an accessibility KPI which is considered a more critical quality issue.
18. Youth Addictive Disease consumers who abstain from use or experience a reduction in use while in treatment
 - Summary Comments and analysis: Data collection for this annual KPI has been place for several years with the target of 56% being met for the 2012 year. Although a NOM indicator for block grants, a more specific KPI has been proposed going forward. This KPI will be replaced with an retention KPI which is considered a more critical quality issue.
19. Individuals meeting community settlement agreement criteria who are enrolled in settlement funded services who state they are satisfied with the services they are receiving

- Summary Comments and analysis: Data collection has been in place for approximately twelve months for this semiannual KPI. Overall an upward trend in consumer satisfaction is noted with the results from the October 2012 – April 2013 time period exceeding the target of 90%.
20. Individuals meeting community settlement agreement criteria who are enrolled in settlement funded series who feel their quality of life has improved as a result of receiving services
- Summary Comments and analysis: Data collection has been in place for approximately twelve months for this semiannual KPI. Overall an upward trend in consumers who feel their quality of life has improved as result of services is noted with the results from October 2012 – April 2013 falling just short of the 90% target. This KPI will continue to be monitored.

The Community Behavioral Health dashboard can be found in Appendix G.

Developmental Disability Programs Key Performance Indicators

The Division of Developmental Disabilities is in the process of evaluating its Quality Management System and processes. An aspect of the evaluation will be reviewing current performance indicators and making adjustments where needed. An outcome of the evaluation will most likely be a change in the current key performance indicators. Once the data from the regional quality reviews has been analyzed, the Division of DD will re-evaluate its current KPIs. (See Appendix H for the DD Programs dashboards).

The remaining current key performance indicators are used to help the Division of DD to determine:

- The level at which individuals are receiving person centered supports and services;
- If the individual is healthy and safe
- The efficiency of specific DD services

Person Centered Supports

Individual Support Plan Quality Assurance

Each individual's team of supports should meet annually to develop an ISP that is person centered and supports the individual's needs and desired goals. An ISP QA Checklist tool was initially developed by the state to ensure the ISP includes all necessary requirements as dictated by the state, and that it helps ensure the individual has a healthy, safe, and meaningful life.

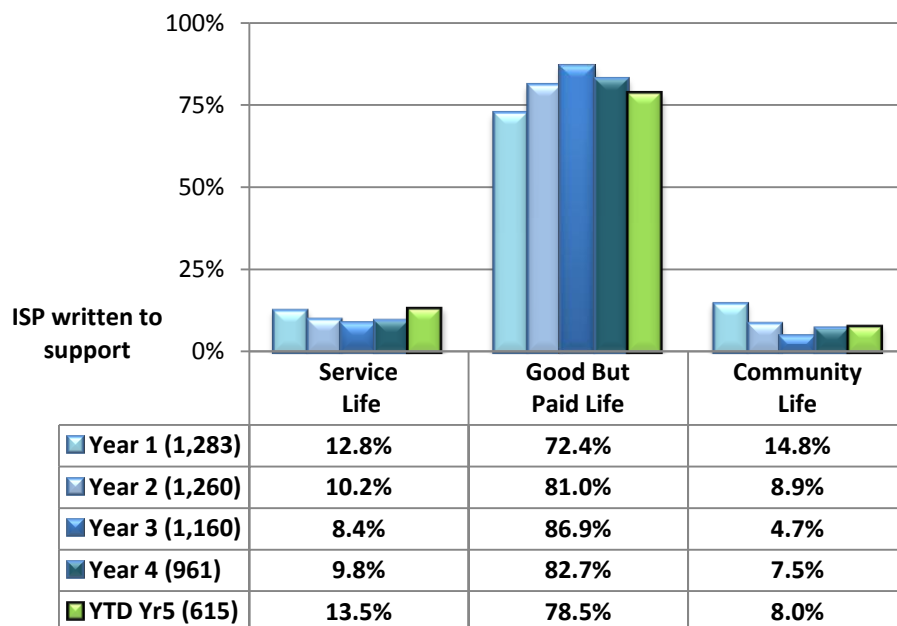
Using the ISP QA Checklist, the Division's external quality review organization (Delmarva) determines an overall rating for each individual reviewed, based upon the degree to which the ISP is written to provide a meaningful life for the individual receiving services. There are three different categories for each ISP.

1. Service Life: The ISP supports a life with basic paid services and paid supports. The person's needs that are "important for" the person are addressed, such as health and safety. However, there is not an organized effort to support a person in obtaining other expressed desires that are "important to" the person, such as getting a driver's license, having a home, or acting in a play. The individual is not connected to the community and has not developed social roles, but expresses a desire to do so.

2. Good but Paid Life: The ISP supports a life with connections to various supports and services (paid and non-paid). Expressed goals that are “important to” the person are present, indicating the person is obtaining goals and desires beyond basic health and safety needs. The person may go out into the community but with only limited integration into community activities. For example, the person may go to church or participate in Special Olympics. However, real community connections are lacking and the person indicates he or she wants to achieve more.
3. Community Life: The ISP supports a life with the desired level of integration in the community and in various settings preferred by the person. The person has friends and support beyond providers and family members. The person has developed social roles that are meaningful to that person, such as belonging to a Red Hat club or a book club or having employment in a competitive rather than segregated environment. Rather than just going to church, the person may be an usher at the church or sing in the choir. Relationships developed in the community are reciprocal. The ISP is written with goals that help support people in moving toward a Community Life, as the person chooses.

The distribution of the ISP rating for results to date this year is presented below, with findings from previous years provided for comparative purposes. Between Year 1 and Year 3 there was a decline in the proportion of ISPs written to support a Community Life, but since that time this has trended up to Year 2 levels (8.0%). At the same time, there had been a decrease in the proportion of Plans written to support a Service Life, but this has increased to greater than in Year 1 (13.5%). The proportion of Plans written to support a Good But Paid life increased from Year 1 to Year 3, but has shown a decline since that time.

ISP QA Checklist Results July 2008 – March 2013



- Individuals in a group home or living with a parent were most likely to have an ISP written to support a Service Life.
- Almost all of the 46 individuals living in a Host Home had a plan written to support a Good But Paid life.
- Living in your Own Place appears to be most beneficial in terms of how the ISP is written, 21 percent supporting a Community Life.
- People in the youngest and oldest age groups were most likely to have a Plan written to support a Service Life.

The Division of DD will research how other states are supporting community integration for people with developmental disabilities. Best practices and effective methods of supporting people to develop social roles and connect with their community could be the focus. The anticipated completion date is February 2014. In 2011, the Division convened a stakeholder workgroup to develop a new ISP process and electronic template. The new process will assure a more person-centered approach. The Division has begun developing strategies to implement this new system which by design ensures the person's goals and needs change as the person desires change and/or as necessary. The new system is scheduled to go online April 2014 with training to begin January 2014.

Health and Safety

The Division of DD utilizes the National Core Indicator Survey to gather directly from individuals and their families, the satisfaction they feel with their services and supports; and to gather additional data on the health and safety of the those individuals.

Key indicators that have been reviewed include vaccines, dental examinations, annual physicals, and the perception of safety and dignity.

The 2011-2012 National Core Indicator data shows:

- 63% of respondents from Georgia and 77% of respondents across NCI States were reported to have had a flu vaccine in the past year. This is down slightly from 65% last year.
- 70% of respondents from Georgia and 80% of respondents across NCI States were reported to have had a dental exam in the past year. This is down significantly from 78% last year.
- 90% of respondents from Georgia and 90% of respondents across NCI States were reported to have had a physical exam in the past year. This is down slightly from 91% last year.
- 89% of respondents from Georgia and 82% of respondents across NCI States reported they never feel scared at home. This is up significantly from 86% last year.

- 96% of respondents from Georgia and 94% of respondents across NCI States reported they are treated with dignity and respect. This is down slightly from 97% last year.

Georgia received the 2011-2012 NCI data mid-July 2013. Once the data is reviewed and analyzed, strategies will be developed over the next several months to address the deficiencies related to vaccinations and dental services.

Georgia has regularly scored low on dental services compared to other NCI states. These low scores were brought to the attention of the DBHDD Medical Director and on October 25, 2012 the Executive Quality Council. As a result of the high prioritization by the EQC, a possible performance improvement project between the Division of Developmental Disabilities and the Georgia Department of Public Health was discussed. Since October 2012, the DBHDD Medical Director has been working in partnership with the Georgia Department of Public Health to develop options to increase the availability of dental services to this specific population. One option being discussed is utilizing DBHDD dentists to provide dental services to DD consumers in PH clinics. As an interim measure, the dental clinics at all DBHDD state hospitals will remain open and available to individuals with DD who are supported by DBHDD. A communication plan regarding the availability of dental clinics for individuals with DD will be developed by December 1, 2013.

Efficiency of Services

In 2011, as part of the ADA Settlement Agreement and as a direct result of the prohibition on DD individuals being admitted to state hospitals, the Division of DD created the Georgia Crisis Response System for Developmental Disabilities.

The goal of this system is to provide time-limited home and community based crisis services that support individuals with developmental disabilities in the community, and provide alternatives to institutional placement, emergency room care, and/or law enforcement involvement (including incarceration). These community based crisis services and homes are provided on a time-limited basis to ameliorate the presenting crisis. The system is to be utilized as a measure of last resort for an individual undergoing an acute crisis that presents a substantial risk of imminent harm to self or others.

The Georgia Crisis Response System (GCRS) includes intake, dispatch, referral, and crisis services components. An essential part of this system is the assessment of the individual situation to determine the appropriate response to the crisis. Entry into the system takes place through the Single Point of Entry (SPOE) system. Intake personnel determine if an individual meets the requirements for entry into the system and initiate the appropriate dispatch or referral option. If a Developmental Disability (DD) Mobile Crisis Team is dispatched to the crisis location, this team assesses the need for a referral or crisis services. Crisis services occur through intensive on-site or off-site supports.

Two main components of the system are Intensive In-Home Supports and Intensive Out of Home Supports.

The intent of Intensive In-Home Support is to stabilize the individual through behavioral intervention strategies provided under the recommendations of the DD Mobile Crisis Team. The services are provided in the individual's home and may be provided 24/7 for a limited period of time. From July 1, 2012 through June 30, 2013, 12% of crisis incidents resulted in the need for intensive in-home supports.

The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports, on a time-limited basis. Intensive Out-of-Home Supports are to be provided by Crisis Support Homes, which are to serve no more than four adult individuals simultaneously. Individuals under the age of 18 years must not be served in a Crisis Support Home. Those individuals are served in the Divisions Temporary and Immediate Support Home. From July 1, 2012 through June 30, 2013, 16% of crisis incidents resulted in the need for intensive out-of-home supports.

Crisis data shows that the system is operating as it should, with the individual receiving crisis supports in the least restrictive environment as possible. The Division of DD has experienced, however, an ongoing issue when attempting to support dually diagnosed individuals. Behavioral Health has just recently implemented its own Mobile Crisis Response System, and the Division of DD is partnering with Behavioral Health to address this shared population.

Quality Monitoring Activities

Complaints and Grievances

The Office of Public Relations (OPR) constituent services section, received 158 complaints, grievances and inquiries between December 1, 2012 to May 31, 2013. Of the 158 complaints received there were 45 issue categories that included addictive disease; adult services DUI intervention, recovery support; community care; developmental disability host homes, NOW and COMP Waiver, eligibility, exceptional rate, planning list, self directed services; investigations; clients rights violation; open records request; mental health access and placement; provider enrollment; mental health residential placement; mental health access to services; mental health inpatient discharge; provider network, etc.

The most frequent issue of concern was related to developmental disabilities. Fifty-one percent (51%) of the developmental disability cases were pertaining to funding and eligibility for the New Options Waiver (NOW) and the Comprehensive Supports (COMP) Wavier. While thirty-five percent (35%) of the developmental disability cases were received from family members, friends and advocates, nearly thirty-six percent (36%) of the constituent cases were initiated by the Governor's office and members of the Georgia General Assembly. The second most frequent category of concern was mental health. The Office of Public Relations received 51 cases concerning mental health. These cases were triaged to state office staff as well as regional staff to address each individual's concern within 5 to 7 business days depending on the nature of the complaint or inquiry. Family members express the need for long term mental health treatment facilities and services for their loved ones in their communities. This analysis was shared with EQC at the July meeting.

The Office of Public Relations goal is to review its intake process to ensure constituent concerns are being addressed in a timely and effective manner. This review will allow us to determine if the current intake process is sufficient to meet future needs.

Hospital and Community Incident Data December 2012 – May 2013

The following incident review covers death reports and critical incident reports received in the Office of Incident Management and Investigations from December 1, 2012, through May 31, 2013. The total incidents received by month for hospitals and community providers are included in Tables 1 and 3 below. The tables also provide a comparison for the current report period (December 2012 – May 2013) with the prior six month period (June 2012 – November 2012).

Hospital Incident Data

As Table 1 indicates, the total number of hospital incidents for the report period was 4,212 compared to the prior 6 months of 4,256. Overall a slight reduction occurred between the two report periods of -1.03%.

Table 1: Total Incidents by Month

HOSPITAL						
Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Total
758	641	764	750	732	611	4,256
Dec-12	Jan-13	Feb-12	Mar-13	Apr-13	May-13	
753	738	624	713	736	648	4,212

The five most frequent hospital incidents reported during this review period are listed below in Table 2. Incident types A03 and A04, Aggressive act to another individual-Physical and Aggressive act to staff-Physical, occurred more often than all others and account for 47.6% of the total number of incidents reported. This number did not change significantly from the prior six months. However, Aggressive act to another individual-Physical decreased 0.6% and Aggressive act to staff-Physical decreased 6.6%. A01 Accidental Injury, A02 Aggressive act to self and A25 Falls round out the most frequent reported hospital incidents. These five incident types account for 73.6% of the total number of incidents reported.

Table 2: Most Frequently Reported Hospital Incidents

Hospital Incident Type	Total
A03-Aggressive act to another individual-Physical	1067
A04-Aggressive act to staff-Physical	936
A01-Accidental Injury	400
A02-Aggressive act to self	362
A25-Falls	336

Community Incident Data

The total community incidents for the report period were 1,900 compared to the previous 6 months of 1,851, reflecting an increase of 2.65%.

Table 3: Total Incidents by Month

COMMUNITY						
Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Total

326	316	324	292	325	268	1,851
Dec-12	Jan-13	Feb-12	Mar-13	Apr-13	May-13	
273	321	294	329	332	351	1,900

See Table 4 below for the five most frequently reported community incidents.

Table 4: Most Frequent Occurring Community Incidents

Community Incident Type	Total
C-Hospitalization of an Individual in a community residential program	621
C-Individual injury requiring treatment beyond first aid	187
C-Incident occurring in the presence of staff which requires intervention of law enforcement services	181
C-Individual who is unexpectedly absent from a community residential program or day program	158
C-Alleged Individual Abuse-Physical	101

Hospitalization of an Individual in a community residential program occurred more than all other community incident types combined and increased almost 13% from the prior six month period. Individual injury requiring treatment beyond first aid increased 1.6%; Incident occurring in the presence of staff which required intervention of law enforcement services increased almost 15%; Individual who is unexpectedly absent from a community residential program or day program increased 22.5%; and Alleged Individual Abuse-Physical decreased almost 11%.

Community Incident Data – Behavioral Health Services

Community Incident Data can be further categorized by disability type. Community behavioral health providers reported 621 deaths and critical incidents during this report period or 33% of the total number of community incidents. The incident types requiring an investigation and reported most frequently for Behavioral Health were Hospitalization of an Individual in a community residential program, Incident occurring in the presence of staff which requires intervention of law enforcement services, Individual who is unexpectedly absent from a community residential or day program, Criminal Conduct by Individual and Individual injury requiring treatment beyond first aid.

Community Incident Data – Developmental Disability Services

Community developmental disability providers reported 1279 deaths and critical incidents or 67% of all incidents during this report period. The incident types requiring an investigation and reported most frequently for developmental disabilities were Hospitalization of an Individual in a community residential program, Individual injury requiring treatment beyond first aid, Incident occurring in the presence of staff which requires intervention of law enforcement services, Individual who is unexpectedly absent from a community residential or day program and Alleged Individual Abuse-Physical.

Community Mortality Reviews

During this review period the Community Mortality Review Committee met three times to review the unexpected deaths of individuals receiving DBHDD services. (*Note: Category III deaths that require no investigation per policy were not reviewed unless the death was also investigated.*) A total of sixty four unexpected deaths were reviewed during this period with

twenty one reviewed in February, twenty three in April and twenty in May 2013. As a result of these additional reviews, one death was reinvestigated by an OIMI Investigator; and additional information was obtained from the investigator(s) and/or provider(s); recommendations were made for additional corrective action(s); and changes in investigative processes have been recommended.

Patterns and Trends

During this report period, the Office of Incident Management and Investigation compiled, analyzed and provided information regarding incident patterns and trends to the Community Behavioral Health Program Quality Council (CBH PQC), the DBHDD Executive Quality Council (EQC), the Division of Developmental Disabilities, the Division of Addictive Diseases, the Division of Community Mental Health, the Suicide Prevention Coordinator, and the Regional Hospital Administrators, Risk Managers and Incident Managers. Based on a review of the data, additional data needs were identified and provided in subsequent meetings. The information has been used for quality improvement purposes to identify providers who may require technical assistance and/or training. Information/training has been provided to two provider groups during this review period.

Hospital Peer Review and Credentialing

During this reporting period the Medical Staff Bylaws have been updated and the Hospital System leadership has improved its management of credentialing of contracted services to address the need for primary source verification of credentials and to include performance indicators in contracts that are integrated into the Quality Management and peer review structures.

Hospital Utilization Review

Utilization review data were used to help determine the implications of, and to inform the planning for the closure of Southwestern State Hospital. It has helped to estimate the capacity of community-based programs to accommodate the needs resulting from that closure. The Hospital System and Regions continue to monitor and address issues related to rapid readmissions (less than 30 days), people with 4 or more admissions in a year, and people with 10 or more admissions in a lifetime.

Adult Mental Health Fidelity Reviews

Assertive Community Treatment Fidelity Reviews are conducted annually for all 22 state contracted ACT teams. Between January-June 2013 fourteen Fidelity Reviews were completed using the 28-item DACTS model for Fidelity, the 22nd team became operational in April 2013 and in accordance with best practice will be reviewed at the six month operational status time period. Once the DBHDD ACT Fidelity Review Team completes the review, results of the Fidelity Review are given to the ACT team, the regional office in which the team operates, the DBHDD Adult Mental Health Director and other departmental leadership, and results are provided to the ACT Subject Matter expert hired as part of the DOJ Settlement. This is followed by an exit interview inclusive of provider, regional and state staff for detailed discussion of the review outcome and report. Outcomes are also discussed with the PQC.

Review items that are found to be below the acceptable scoring range; a score of 1 or 2, result in a Corrective Action Plan (CAP) which each team develops and submits for acceptance to the

regional and state office. ACT teams are contractually expected to minimally obtain a DACTS mean score of 4.0 and total score of 112. Of the twenty one teams that have received a Fidelity Review, fifteen achieved a score within the acceptable range of fidelity, indicating that they are serving the appropriate population, maintaining an acceptable caseload, delivering the service with intended frequency and intensity, providing crisis response, conducting effective daily team meeting discussion of consumers, engaging formal and informal supports, being involved in hospital admission and/or discharges and consistently delivering 80% of the teams services in the community. At the time of the review, six teams scored below the acceptable range of fidelity. Some of those areas of needed attention are, increasing team involvement in hospital admissions and discharges, strengthening delivery and documentation of contacts with consumer's informal support system, increasing the stability of staffing and reducing turnover and increasing co-occurring disorders treatment. All six teams have submitted or are in the process of submitting CAP's, and have received technical assistance and have demonstrated improvements in most areas.

Supported Employment Fidelity Reviews are conducted annually for all twenty two state contracted SE providers. In the current fiscal year a total of twenty one Fidelity Reviews were completed using the 25-item IPS model for supported employment, the 22nd SE provider became operational in the spring and will receive a review in the fall. Once the SE Fidelity Review is complete, results are given to the SE provider, the regional office in which the team operates, the DBHDD Adult Mental Health Director and other departmental leadership and results will be provided to the SE Subject Matter expert hired as part of the DOJ Settlement. This is followed by an exit interview inclusive of provider, regional and state staff with a detailed discussion of the review outcome and report. Outcomes are also discussed with the PQC.

Review items that are found to be below the acceptable scoring range; a score of 1 or 2, will result in a Quality Improvement Plan (QIP) which each team develops and submits for acceptance to the regional and state office. SE providers are contractually expected to minimally obtain an IPS total score of 74. Of the twenty one providers who have received a Fidelity Review, fifteen achieved a score within the acceptable range of fidelity, indicating that they are effectively integrating SE and mental health, maintaining collaboration with GVRA, demonstrating clearly defined employment duties for SE staff, implementing zero exclusion, rapidly engaging consumers in competitive job search, assessing consumer's interests and making job placements based on identified interests and skills. At the time of the review, six providers scored below the acceptable range of fidelity. Some of the areas of needed attention are, increasing collaboration with GVRA, connecting consumers with competitive job options, integration of SE and mental health treatment team, engaging in sufficient employer contacts and having ample executive leadership support. These providers have submitted or are in the process of submitting QIP's and are receiving technical assistance in order to improve operation in areas of deficiency.

QM Audits: Quality Service Reviews of Adult Behavioral Health Community Providers

As a component of DBHDD's quality management system and the Settlement Agreement, a quality audit/service review of a sample of individuals meeting Settlement Agreement criteria and who were enrolled in settlement funded services was created and implemented beginning October 2011. The audit was designed to follow the care of an individual throughout the system of care as they transitioned between services and as they received multiple ongoing services.

In an effort to further align the audits/service reviews with the Department's consumer centric focus on consumer choice, satisfaction, and how services impact an individual's quality of life; the audits were redesigned in November 2012. The redesigned audits focus on the perceptions of the individuals served, their level of satisfaction with services, how the service has improved their quality of life, and whether there are any needs that currently are not met by the design, implementation, or availability of a service. The audit process continues to include interviews with individuals served, interviews with leadership and direct care staff, on-site observations, and a review of medical records. Policies, procedures and relevant documents related to the performance improvement and risk management processes are also reviewed where applicable. New audit criteria were developed between November 2012 and January 2013 and a Pilot Survey was conducted from February 5, 2013 to February 7, 2013. The criteria were further refined based on the results of the pilot study and the third cycle of audits commenced using the revised audit tool on March 4, 2013 with reviews in Region 4.

Data collected on individuals enrolled in Settlement services has been reviewed since the implementation of the Quality Management Audit process. A pattern emerged where individuals were being repeatedly admitted to Crisis Stabilization Units without subsequently being enrolled in more intense Settlement services such as Assertive Community Treatment. As a result of this pattern, the Quality Management Audit was designed to include a review of the discharge planning processes of a sample of these individuals, at each Crisis Stabilization Unit reviewed. The purpose of this review is to identify patterns or gaps in service in order to identify changes that may be made to increase enrollment and decrease recidivism for individuals who meet Settlement criteria. This review process is in its early stage and there has not been sufficient data collected to identify significant trends or patterns at this time.

With the revised design of the audits, it was determined that a database was needed which will assist in data analysis. In February 2013, the Quality Management Department began working with the DBHDD's IT Department to create such a database. The database is currently in its design stage with an anticipated completion date of December 2013. Until the database is finalized, the QM Audits are analyzed at basic levels for feedback to providers and program directors and to identify global issues relevant to the provision of services.

Eight organizations providing fourteen services participated in the audit/service review process between March 3, 2013 and July 2, 2013. Individuals reviewed were enrolled in the following services: Assertive Community Treatment (ACT), Community Support Team (CST), Case Management (CM), Supported Employment (SE), Crisis Stabilization Units (CSU) and Peer Mentor services. Sixty-three individuals enrolled in these services were audited; eleven of those individuals were enrolled in more than one service. Seventy-six percent (76%) of individuals chosen for the review consented to and were interviewed. The numbers below reflect reviews conducted within each service.

Cycle 3 Reviews

Services	Providers	Teams	Charts Audited	Individual Interviews	Staff Interviews
Assertive Community Treatment	4	4	28	20	16
Community Support Team	1	1	6	4	2
Case Management	1	1	4	3	1
Supported Employment	4	4	18	15	10
Peer Mentor	1	1	NA	5	3
Crisis Stabilization Units	3	3	13	NA	6
Totals	14	14	69	47	38
Unduplicated Totals	8	14	69	38	38

On the last day of the audit, an exit interview is held with the provider during which the audit's preliminary findings are discussed. The data collected from each audit is reviewed and compiled. Citations of non compliance are written when deficits are noted within a service. A final report is completed, including the citations and consumer based feedback, and forwarded to each provider's leadership, the respective regional office, and to central office staff to include the ADA Settlement Agreement Director, Adult Mental Health Director, Director of the Office of Recovery Transformation, and Assistant Commissioner. Semi-annual reports are completed allowing for trends within a service and across providers to emerge. To date, no trends during this time period have been identified as this audit cycle is still in process.

Child and Adolescent Community Mental Health Programs (CAMH)

The first and second quarterly reports related to Quality Improvement data were produced for all programs (PRTF's, CMEs/CBAY, and CSUs except Clubhouses which is monthly) by the Georgia State University Center of Excellence for Child and Adolescent Behavioral Health. The data and formats of the reports were reviewed. Most quality improvement consortiums agreed to move toward a provider report card instead of the extensive report (see Attachment) for an example of the new report card). The CME/CBAY Quality Council is scheduled to review the report card in July 2013. Additionally, the majority of the quality improvement consortiums found that some of the data is being collected differently by providers and determined that there is more work that needs to be done to review and modify quality improvement key performance indicators, as well as clarify and standardize data collection procedures for more reliable and valid data. The target completion date for this work is September 30, 2013.

In January 2013, Community Mental Health held a training and technical assistance symposium in Macon, GA. All Child & Adolescent and Adult Providers were invited to participate and receive training on how to increase/improve the quality of the service(s) they provide. Topics were varied and included, but were not limited to: data informed decision making, cultural competence, and improving clinical competence. Approximately 350 people participated in this training. The next symposium will be held August 13-14, 2013 in Macon, Georgia.

Mental Health Coalition Meetings

A gathering of all Supported Employment providers and a gathering of all Assertive Community Treatment providers are facilitated on an every other month basis by DBHDD staff. These meetings are vehicles for disseminating and gathering information, maintaining open

communication, promoting provider collaboration and fostering the partnership between the Department and provider agencies. This forum allows for discussion of programmatic operations and performance (including key performance indicators), informal presentations/in-service, discussion of Departmental policies and any other matters of relevance for these evidence-based practices. Coalition meetings have functioned as forums of discussion that have provided an impetus for several ACT policy adjustments, including, length of authorization, CTP units increase, group therapy units increase, group therapy staff ratio adjustment and billing for collateral contacts and for increased usage of transportation funds in SE. Each service specific coalition meeting is held in Macon for ease of access, and there is a call in number for those unable to be present. There were eight ACT Coalition meetings held between August 2012- July 2013. There were five SE Coalition meetings held between August 2012- June 2013.

Behavioral Health Contracted External Review Organization (ERO)

APS Healthcare is the External Review Organization (ERO) for DBHDDs behavioral health services. Many of the functions and products provided by this vendor contribute to the Departments quality management of the Provider Network. These elements include training, technical assistance, prior authorization for services, provider audits, and provider billing and service provision data. Several notable outcomes occurred during the time period of this report regarding provider network management, training opportunities, and authorization processes.

Audits:

The ERO conducted 158 audits between the January 2013 - June 2013 time period. In an effort to develop a systematic review and response to audit findings, DBHDD implemented *Policy 01-113, Noncompliance with Audit Performance, Staffing, and Accreditation Requirements for Community Behavioral Health Providers*, in September 2012. This policy provides a protocol for DBHDD to respond to providers who receive failing audit scores, do not meet minimum staffing requirements, or fail to achieve or maintain accreditation. During this reporting period, DBHDD has implemented the policy for several providers who have failing audit scores and the Department continues to refine the protocols which support these actions. DBHDD has made improvements to tracking and communicating audit scores both internally and with the Department of Community Health (DCH). Staff at DBHDD have worked to collaborate with DCH to develop procedures regarding consistent management of providers which fail to achieve compliance with DBHDD standards as evidenced by failing audits. As a result of this collaboration, several protocols have been agreed upon and dialogue continues between the two Departments to ensure a consistent and efficient process of responding to provider deficiencies via corrective or adverse action.

DBHDD and the ERO completed the annual evaluation of the ERO audit tool. Adjustments were made to the Programmatic Audit Tool for Psychosocial Rehabilitation Individual, Case Management, Intensive Case Management, and Assertive Community Treatment to align with current service definitions and fidelity models. The current audit tools can be found on the APS Knowledgebase page at www.apsero.com

Training:

The ERO has provided many training opportunities to the network during the report period. In addition to the onsite technical assistance provided at each Audit Exit Interview, APS has also offered both broad and targeted information to the provider network:

- In January, APS Healthcare sponsored a Statewide Provider Training Forum in Macon, Georgia. This event included training regarding evidenced based practices, use of ERO tools for quality improvement (e.g. audit scores, utilization reports), and responding to needs of specific populations (i.e. deaf services & homeless populations).
- Participation and training as an element of the Georgia Certified Peer Specialist training.
- Provided on-site regional training in Region 4 as requested by the providers. This training focused on ACT, Psychosocial Rehabilitation, and general ERO practices. The result of this meeting resulted in improved communication and collaboration between the ERO and Providers.
- Continued offering of the Ambassador Program for new providers and providers' new staff members.

In addition, the ERO has been instrumental in assisting the Department with additional training opportunities related to Assertive Community Treatment. Following feedback received from providers, DBHDD and the ERO partnered to provide training regarding ACT services in multiple venues. In addition to the ERO's regular attendance at ACT Coalition Meetings, APS provided technical assistance specific to ACT via:

- Targeted feedback to DBHDD regarding ACT authorization and audit processes and evaluation of inter-rater reliability. One of several outcomes of this discussion was the development of an extended initial authorization period of 1 year.
- In preparation for the transition to a 1-year initial authorization, APS provided two webinars to providers to outline the new process. These meetings also provided ongoing technical assistance regarding Documentation Requirements, Admission and Continuing Stay Criteria, and Transitioning to-and-from intensive services.

Service Utilization & Authorization:

During the report period, licensed clinicians at the ERO have manually reviewed 39,468 authorization requests for community services. Of those, 1,792 authorization requests were specific to ACT services. As identified above, the ERO and DBHDD modified the authorization for ACT services to extend the initial authorization from 6 months to one year.

Claims information provided by the External Review Organization also informed key decisions related to the content of service authorization packages. In the Spring of 2013, DBHDD used utilization data to perform a review of units authorized for several service packages and to identify trends. This review was conducted by a panel of experienced clinicians and operational experts using a zero-based methodology that examined each service individually and in the context of other services available. The review resulted in a recommendation and subsequent changes to selected authorization packages. While there was some reduction in the number of units authorized in each package, the changes do not equate to a reduction or limit to services.

The primary aim of the initiative was to support services at levels sufficient to treat and support individuals at all levels of care. The changes to the authorization array promote recovery and resiliency through the use of a comprehensive and robust array of case management/skills development services combined with appropriate psychiatric treatment, individual, group, and family therapy services rather than relying heavily on one or two isolated service modalities for

individuals with complex needs. DBHDD continues to monitor utilization trends for continuous quality improvement activities.

Implementation and Results of Best Practice Guidelines:

Beck Initiative

The Beck Initiative is a collaborative clinical, educational and administrative partnership between the Aaron T. Beck Psychopathology Research Center of the University of Pennsylvania (PENN) and Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) to implement recovery-oriented Cognitive Therapy (CT-R) training and consultation throughout the DBHDD network. Fusing the recovery movement's spirit and cognitive therapy's evidence base, CT-R is a collaborative treatment approach that prioritizes attainment of patient-directed goals, removal of obstacles to the goals, and engagement of withdrawn patients in their own psychiatric rehabilitation. Through intensive workshops and ongoing consultation, tangible tools to help remove roadblocks to recovery of people with severe mental illness are placed in the hands of care providers across the network. CT-R provides the fabric for promoting continuity of care with the goal of helping affected individuals achieve a sustained integration in the community.

Broad Project Goals

- To promote hope, autonomy, and engagement in constructive activity, for individuals served by agencies in the DBHDD network;
- To establish CT-R as a standard practice of care for people served within DBHDD agencies;
- To promote the sustained implementation of CT-R into the DBHDD network;
- To improve the professional lives of therapists in the DBHDD system;
- To conduct program evaluation to examine outcomes such as client attrition, service use, recidivism, therapist turnover, and the sustainability of high-quality CT in DBHDD settings;
- To utilize the evidence-based practice of CT-R in the Department as roadmap for delivering recovery-oriented care; and
- To serve as a model for other large mental health systems.

Outcomes: Region 4

In Region 4, 110 provider staff became trainees. These staff work for outpatient Behavioral Health providers (therapists, case managers, peer specialists, therapists) and State Hospital inpatient units (nurses, psychiatrists, psychologists, social workers, health workers, etc). At the time of this report, at least 110 individuals (eighty five from the outpatient setting and twenty five from the inpatient setting) with severe and persistent mental illness have received CT-R.

When comparing pre-training to post-training, the number of trainees having contact with SCZ (schizophrenia) progressed from 16 to 34, the number of patients receiving individual therapy progressed from 0 to 85 and the average length of contact progressed from 17.5 to 50 minutes. In summary, the CT-R training program increased trainee understanding and effectiveness, brought

outpatient clinicians to competency, enabled mental health professionals to more effectively help individuals who are in recovery move toward the recovery of their choosing. Individual accounts of the impact of the application of these techniques with patients struggling with their psychotic symptoms include multiple cases in which individuals have been discharged from hospital stays and not re-hospitalized as often or not at all.

FY: 14 Kick-Off Meeting – Beck Team

DBHDD Central Office staff, its Training Department and the Regional Offices Leadership coordinated a Kick-Off Meeting with the Beck Team which was held on July 8, 2013. The purpose of the meeting was to discuss the Recovery-Oriented Cognitive Therapy for Program Year 2013-2014 that will be implemented in Regions 1, 3 and 6. The meeting focused on the Cognitive Therapy and Recovery: CT-R, Region 4's Outcomes, the training program at a glance and planning for Regions 1, 3 and 6.

FY: 14 - Project Plan

Providers in Region 6 will receive this training August 2013 – February 2014, following Regions 1 and 3 will be trained February 2014 – August 2014. The CT-R Training Program will consist of workshops (Phase 1), 6-month consultation (Phase 2) and sustainability (Phase 3). The training sites and providers receiving the training will be the State Hospital (key providers), the community (assertive community treatment teams, community support teams and community service boards) and supervisors.

Additional details on Cognitive Therapy and the CR-T Training Program may be found in Appendix I.

Suicide Prevention Program

DBHDD recognizes suicide as a significant public health issue in the State of Georgia and has developed a suicide prevention program. The program's goals include training providers in techniques to:

- prevent suicide deaths,
- reduce other suicidal behaviors including attempts,
- reduce the harmful after-effects associated with suicidal behaviors, and
- improve mental health of Georgians through primary prevention activities, access to care, early intervention, crisis treatment and continuing care.

In order to address the issue of increasing access to care for people at increased risk for suicide in Georgia communities, the Suicide Prevention Program supports two evidence based gatekeeper trainings. Gatekeepers act as outreach liaisons that provide their community with information about how to identify someone at high risk of suicide, how to encourage the person to get help, and how to access behavioral health and crisis services. The programs are called: *Question, Persuade, and Refer (QPR)* and *Mental Health First Aid (MHFA)* and are for both adults and youth. Both programs teach community members to recognize the signs of suicidal behavior and direct individuals to assistance. Between December 1, 2012 and May 31, 2013 DBHDD trained at least 250 Georgia citizens in QPR and 350 citizens in Mental Health First Aid. Twelve QPR trainings, twelve adult Mental Health trainings and three Youth Mental Health First Aid trainings were held in DeKalb, Henry, Gordon, Fulton, Newton, Haralson, Gwinnett, Walker, and Dougherty counties.

To help expand the use of QPR in Georgia communities and support its sustainability, the Suicide Prevention Program funded a QPR Train the Trainer in Albany on May 30, 2013 and added fourteen new certified trainers to the existing group of 189 certified QPR trainers throughout the state. Between January 1 and May 31 2013, eleven of the fourteen recently trained Georgia Parent Support Network Mental Health First Aid trainers were mentored by experienced Mental Health America, MHFA trainers and are prepared to provide Youth Mental Health First Aid.

The Suicide Prevention Program, through its contractor, The Suicide Prevention Action Network of Georgia (SPAN-G), has revised the suicide prevention training segments in the Crisis Intervention Team (CIT) trainings coordinated by National Alliance on Mental Illness (NAMI) given to law enforcement and first responders throughout Georgia. In addition to identification of suicide, the program now contains information about supporting and managing suicide survivors at the scene of a death, and information on self-care. Between December 2012 and May 2013 six pilot trainings used the new curriculum segment with very positive reviews. In May, the new curriculum was delivered to be included in the national revision of the entire CIT curriculum due to be published in 2014.

DBHDD also participates in the federal Garrett Lee Smith Youth Suicide Prevention (GLS) Program. In Georgia the program focuses on developing comprehensive suicide prevention programs within the schools. These programs include gatekeeper training for school staff and developing protocols and referrals for getting young people at risk of suicide to help. Year one of the three year funding cycle focused on getting seven targeted school systems on board. Between January 1 and May 31, 2013 DBHDD received agreements to participate from all seven of these school systems: Atlanta Public Schools, Lowndes County Schools, Gwinnett County Schools, Dublin City Schools, Laurens County Schools, Treutlen County Schools, and Baldwin County Schools.

Suicide Prevention Program staff analyzed the suicide deaths and serious attempts reported to DBHDD and the results of the analysis indicated the system level circumstances associated with suicide, included:

- lack of a common definition in reporting and communicating suicidal behaviors
- lack of an effective process for identification of people at risk of suicide
- inconsistent use of an assessment tool to identify levels of risk
- inconsistent use of evidence-based intervention tools for people at high risk of suicide
- lack of communication of suicide risk when individuals moved between levels of care and in and out of care or dropped out of care
- lack of follow-up for people at risk of suicide
- lack of use of psycho educational tools for family members and caregivers so they could support suicide prevention efforts in the home or community for the individual at risk of suicide.
- lack of support for survivors of suicide, such as family members and friends or professional survivors

Program staff worked with experts from the New York State Psychiatric Institute consisting of Dr. Barbara Stanley from the Suicide Intervention Center and Dr. Kelly Posner from the Center for Suicide Risk Assessment in order to address these findings. Additionally the program staff worked with Dr. Doreen Marshall, Associate Dean of Counseling for Argosy University, to design an evidence-based program for the Department's providers. By the end of 2012 the Suicide Prevention Evidence-Based Practice Initiative (SPEBP) had begun.

From December 2012 through May 2013 the Suicide Prevention Program staff provided a variety of Assessment, Intervention and Monitoring (AIM) process training activities. One hour "Introduction to AIM." webinars began in February 2013 and are ongoing. Four webinars were held between February and May 2013 and reached their capacity attendance at 400 participants. Trainings on the individual tools (C-SSRS, Safety Plan and Monitoring) were also developed and presented four times between January and May around the state, serving another approximately 200 attendees. These trainings were videotaped in order to offer DVDs to providers to support ongoing training within provider organizations. Finally, a day-long skill building day for AIM. was developed and delivered in a cross-training on April 2, 2013 to Military, the Veterans Administration and DBHDD community providers from Ft. Benning, Columbus, and Albany. Sixty people attended this training. A second A.I.M. skill building day for DBHDD providers was held on May 3, 2012 in Macon attracting 160 attendees.

To address the need for information about assessment skills, a series of two *Assessing and Managing Suicide Risk for Mental Health Professionals* trainings provided by the SAMHSA funded Suicide Prevention Resource Center were taught by Dr. Doreen Marshall to clinical leadership in DBHDD provider organizations (140 attendees) on March 18 and April 17, 2013 and received very positive feedback.

Postvention intervening when there has been a suicide death, is becoming more and more a focus of the Suicide Prevention Program. *Working with Those Bereaved by Suicide for Mental Health Providers* were developed by Dr. Doreen Marshall to help behavioral health providers understand how to help those bereaved by suicide in behavioral health settings, including how to help professionals bereaved by suicide. Between September 2012 and March 2013, Dr. Marshall taught six workshops in *Working with the Bereaved*, one in each of DBHDD's six regions to over 100 mental health providers.

Educational and outreach materials (purple packets) were designed that included materials from the Link Counseling Center, the American Association of Suicidology, identification of crisis service providers and crisis telephone numbers. Purple packets are disseminated to survivors of suicide by first responders, mental health professionals, funeral directors, clergy and others who encounter survivors of suicide death. Purple packets were provided to all DBHDD providers who attended provider meetings from December through May in Regions 1, 4, and 6. Between December 2012 and May 2013, over 2,000 purple packets were disseminated throughout the state to DBHDD providers and survivors of suicide.

Within DBHDD the Suicide Prevention Coordinator provides on-site and telephone consultation with providers who have experienced the death of a consumer by suicide. The Suicide Prevention Coordinator participates in meetings of the EQC, the Community Behavioral Health

Program Quality Council, the Developmental Disabilities Program Quality Council, and the Community Mortality Review Committee. Consultation to providers who had suicide deaths between December 1, 2012 and May 31, 2013 included introduction to the EBP Initiative and A.I.M program. As part of its consultation to other agencies in Georgia there were three on-site visits with a school system experiencing a large number of deaths, including suicide deaths.

The Suicide Prevention Program also provides ongoing postvention suicide training to the schools through its LIFELINES: Postvention and LIFELINES: Intervention Programs. Between January and March 2013, four LIFELINES: Postvention trainings and two LIFELINES Intervention trainings were provided to teams of school personnel and community professionals who work with school staff after a suicide death of a young person. Combined, these programs trained over 350 school and behavioral health personnel to respond effectively with care to suicide deaths in the schools.

See Appendix J for additional information about Suicide Prevention and DBHDD's Suicide Prevention Program.

DD Reviews of Individuals Served

The purpose of the Person Centered Review (PCR) is to assess the effectiveness of and the satisfaction individuals have with the service delivery system. The Division of DD external quality review organization (Delmarva) uses interviews, observations and record reviews to compile a well-rounded picture of the individual's circle of supports and how involved the person is in the decisions and plans laid out for that person. The time period for DD data is July 1, 2012 through March 31, 2013. At the time of this report, data from April 1, 2013 through June 30, 2013 was still being analyzed. Information in Table 1 provides a general description of the 615 individuals interviewed through a Person Centered Review (PCR, N = 403) or Quality Enhancement Provider Review (QEPR, N= 212) process between July 2012 and March 2013. Males continue to represent a larger proportion of the sample. While close to nine percent of individuals already established in the community have a Profound Intellectual Disability, the proportion for the Individuals Recently Transitioned to the Community (IRTC) group was close to 51 percent with this type of disability.

Table 1: Demographic Characteristics				
<i>Jul 2012 - Mar 2013</i>				
Region	PCR and QEPR		IRTC	
1	119	19.3%	6	8.0%
2	172	28.0%	25	33.3%
3	157	25.5%	13	17.3%
4	45	7.3%	9	12.0%
5	36	5.9%	16	21.3%
6	86	14.0%	6	8.0%
Gender				
Female	240	39.0%	30	40.0%
Male	375	61.0%	45	60.0%
Age Group				
18-25	54	8.8%	5	6.7%

26-44	313	50.9%	19	25.3%
45-54	140	22.8%	24	32.0%
55-64	80	13.0%	17	22.7%
65+	28	4.6%	10	13.3%
Disability				
Autism	6	1.0%	0	0.0%
Cerebral Palsy	1	0.2%	0	0.0%
Intellectual Disability	554	90.1%	38	50.7%
Profound Intellectual Disability	54	8.8%	37	49.3%
Total	615		75	

- On average, individuals showed positive outcomes at 90.7 percent. This was an increase from the same time period last year.
- Individuals were most likely (96 percent present or higher) to indicate they have privacy (dignity and respect), health, safety and choice of supports and services present in their lives compared to all other expectations in the PCR,
- Individuals were least likely to be involved in the review of their supports and services (76.9%) or to have community involvement (77.4%).
- Approximately 30 percent of individuals interviewed to date had not been developing desired social roles.
- Individuals age 65 and over appear to be more likely to have positive outcomes present, but results for this group are based on only 25 interviews
- With the exception of one individual receiving Transportation services, individuals receiving Prevocational services were least likely to have positive outcomes present

While results from the Person Centered Reviews have improved over the years, data through March 31, 2013, indicate a decline in performance on the Support Coordinator and Provider Record Reviews (PRR). Since Year 3, PRR compliance has decreased from 65.1 percent to 60.5 percent,. Support Coordination Record Review (SCRR) compliance has decreased from 72.9 percent to 61.9 percent over the same time period, and from 78.0 percent in Year 1. In order to address these changes in 2011, documentation training was developed by the Division of DD and presented at various locations across the state. Based on the results of the SCRR and PRR, the Division will revisit the training curriculum and explore why there has been a decreasing performance level. Several focus groups could be used to gather information from providers and support coordinators.

The Division is presently evaluating the functions of Support Coordination. As part of this evaluation, the Division will consider developing additional training focused on specific areas of documentation identified support coordinators continue to struggle with the most year after year.

Please see Attachment (GQMS Year 5 Quarter 3 Report January – March 2013) for additional data and analysis.

DD QM Reviews of Providers

Quality Enhancement Provider Reviews

The purpose of the Quality Enhancement Provider Reviews is to monitor providers to ensure they meet requirements set forth by the Medicaid waiver and Division of DD and to evaluate the effectiveness of their service delivery system. The Quality Enhancement Provider Review (QEPR) has been completed by Delmarva for 25 service providers from July 1, 2012 through March 31, 2013.

- The average compliance score for the 25 providers reviewed to date in Year 5 was 68.8 percent, the same as in Year 4. The Division of DD has not set a target for the compliance scores; however an increase in compliance is desired from one year to the next. Compliance scores for Year 4 were slightly higher than Year 5.
- To date, Year 5 providers performed considerably better maintaining current certification and accreditation, up 21 and 13 points respectively.
- Providers continue to score relatively low in documenting job descriptions (63.2%), completing annual training (64.2%), and receiving training to ensure medication administration rules, laws, regulations and best practices are followed (66.7%).

To address these documentation issues, staff from the Division of DD will continue providing documentation training to providers (see above). Providers failing to complete their annual required training continues to be an ongoing challenge. The Department is developing policies and procedures that will address provider quality improvement strategies. The annual training issue will be a part of that project. Additionally, by March 1, 2014, the Division will develop workgroups including provider representation to develop a training curriculum providers can use to ensure staff receives the annual training as required by the Division. To address training needs around medication administration, law and regulations, the Division of DD implemented in May and June 2013 the training series, **“Quality Medication Management and Healthcare Oversight”**. The series was held statewide and was well received.

During the QEPR, Delmarva worked with each provider to identify strengths and best practices as well as barriers providers face in developing optimal service delivery systems. A total of 290 strengths were identified, and a total of 192 barriers were documented during the reviews completed between July 2012 and March 2013. Providers may identify more than one strength or barrier, but each will be recorded only one time per provider.

- Many of the strengths identified for the twenty five providers reviewed to date in Year 5 reflect areas of respect, trust, responsiveness to needs, improving quality of supports and services, and flexibility.

- Barriers noted by many of the providers include excessive paperwork and lack of financial resources (cost of doing business vs. reimbursement rates), and problems surrounding not having the support plan driven by the person.

Using findings from the QEPR, technical assistance is offered to support providers, including suggestions and guidance to help improve their service delivery systems. The Division of DD has implemented two technical assistance processes: the Follow up with Technical Assistance (FU w/TA) and the Follow Up with Technical Assistance Consultation (FUTAC). The FU w/ TA is conducted 90 days after completion of the QEPR. From July 1, 2012 through March 31, 2013, 31 FU w/ TA reviews and 152 FUTAC were completed.

Providers are tagged to receive a FUTAC through a referral system. The review process utilizes a consultative approach to assist providers in their efforts to increase the effectiveness of their service delivery systems. The focus is to improve systems that meet the needs, communicated choices, and preferences of the individuals receiving services. The FUTAC also supplements the PCR and QEPR processes by affording the Division of DD and contracted providers the opportunity to solicit technical assistance for specific needs within the service delivery milieu.

- FUTACs have been completed in each of the six Regions
- Most of the reviews were onsite (95.4%), referred at the individual level (84.2%), the source of the referral from one of the Regional Office HQMs (82.9%), with the Support Coordinator monthly score of a 3 or 4 as the primary reason for the referral (79.6%).
- Health, Safety and Provider Record Review documentation were most often the Focused Outcome Areas addressed.
- Technical assistance most often included discussion with the provider and brainstorming.

The Regional Offices are taking advantage of the FUTAC process to support the providers.

Please see Attachment (GQMS Year 5 Quarter 3 Report January – March 2013) for additional data and analysis.

DD Transition Quality Reviews

The timeframe for conducting Person Centered Reviews (PCR) for the Individuals who Recently Transitioned into the Community (IRTC) group has been changed. Initially, the IRTC individuals had to be discharged from the hospital and placed with a community provider for at least six months before the Division's external quality review organization (Delmarva) would conduct an initial PCR. The time period was reduced from the mandated six months of community placement to three months.

A total of 75 individuals who transitioned from an institution to the community participated in a Person Centered Review during the period of July 2012 through March 2013. Data from the IRTC is compared to data from the PCR and QEPR processes. Findings show:

- The average percent of positive outcomes met is the same for both groups of individuals (90.5% PCR vs. 89.7% IRTC).
- Results for IRTCs were somewhat higher on two positive outcomes (achieve desired goals and exercise rights) indicating individuals who have transitioned to the community are more likely to achieve those positive outcomes.
- Individuals recently moving into the community scored 49.3 percent in the area of developing desired social roles, considerably less than their counterparts (69.3%).

In May 2013, as a result of reviews conducted by the ADA Independent Reviewer and the Division of DD, a 45 day moratorium on community transitions was put in place. During the moratorium period, the Division implemented a process to review the quality of the 79 individuals who had transitioned to the community since July 2012. Regional Quality Review Teams conducted on site reviews with all 79 individuals. The Division also reviewed approximately 20 providers who were slated to provide supports and services to the additional 40 individuals who were scheduled to transition to the community during May and June 2013. Data from these quality reviews is still being analyzed and will be reported in the next QM report.

The Division of DD is re-evaluating the current transition process, and will be taking additional steps to increase the quality of those transitions. The data gleaned from the reviews conducted during the 45 day moratorium will be used to meet the DD QM work plan goal of ensuring that individuals with DD who transitioned out of state hospitals will receive high quality services. Please see Appendix E, the Developmental Disabilities QM Work Plan for additional information concerning transition quality reviews.

DBHDD Quality Management Training Program

During July 2013, the first QM web based training module (Building a Customer-Focused Quality Management Program) was approved for Department-wide use. A memo to Departmental senior leadership was distributed to assist in communicating the importance of the training. In August, a Department-wide training announcement will be sent to all staff notifying them of the requirement to participate in this mandatory training. The target date for completion of the first module is September 1, 2013. Two additional QM web-based training modules have been developed and will be released using a similar process.

Data Reliability Process

Accurate and reliable data is imperative for the success of the DBHDD QM Program. Some of the DBHDDs data integrity activities include:

Hospital System KPI Data Integrity

The Hospital System Quality Management office has utilized the newly developed performance measure evaluation tool (PMET) to identify and assess those KPIs that need additional work in order to assure data integrity. The Hospital System PQC has prioritized data integrity as an important issue and the Assistant Director of Hospital System Quality Management is working with the Hospital Quality Managers committee to make the needed improvements.

Additionally, a data integrity review/audit tool and process will be developed by December 2013.

Community BH Key Performance Indicator Data Integrity

The majority of the data that comprises the CBH KPIs is received from providers via a monthly programmatic report. Over the past 3 months, this report has transitioned from one received by program staff via e-mail to an online database where providers import the data directly via a portal. Currently the online database is live for Case Management, Intensive Case Management and Community Support Teams. In SFY2014, Assertive Community Treatment and Supported Employment providers will begin using the portal. Once the data is received by DBHDD the data must pass a logic safeguard validation and is reviewed by staff with programmatic oversight of each specific program before it is accepted. Feedback is given to providers when errors or omissions occur and they are required to re-complete and re-send their data once corrected. Technical Assistance is provided as needed.

DD KPI Data Integrity

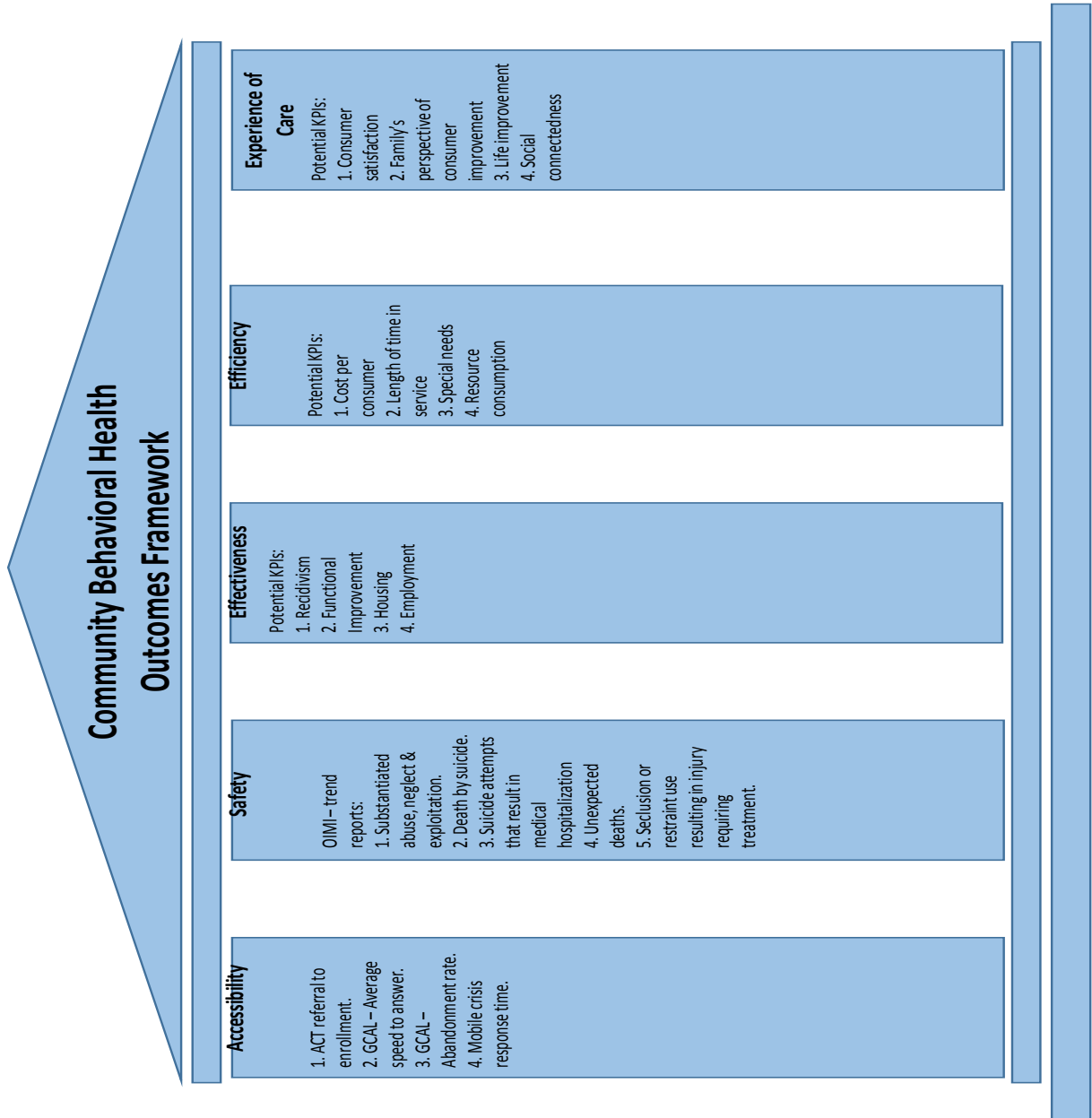
Every two weeks, the analyst working with Delmarva runs a report to identify any incorrect or missing data from the database. This process generates a report from data collected as part of the PCR and QEPR processes which is reviewed by managers, who correct any identified errors. In order to ensure proper handling of possible missing data or data errors, a Data Correction Protocol has been developed to track data errors and necessary correction. For approved reviews or reports, all changes in the data are documented in the “Reopen Review Log”. This information is reviewed periodically by the quality improvement regional manager for possible trends. After the data in the report have been corrected, a new report is generated and distributed as necessary.

Summary

The sections above reference the multitude of quality related activities taking place across DBHDD. Key activities that have taken place between December 2012 and June 2013 include the inaugural DBHDD QM system review; a revision of the DBHDD QM Plan; the revision, standardization and reconfiguration of the KPI dashboard format; the development of a data definition/data collection plan document; the development of a Performance Measure Evaluation Tool (PMET); the development of a report which focuses on incident trends and patterns; the initiation of a comprehensive system wide review of the DD QM system by an external contractor; the implementation of DBHDD QM training for staff utilizing web based modules and significant communication with and training of providers on cognitive therapy (Beck Initiative) and suicide prevention. Additionally a review of KPIs currently being tracked in the hospital, community behavioral health and DD areas has begun.

During the upcoming six months, quality management activities will focus on using the PMET to evaluate the current KPIs, developing new and/or modifying existing KPIs, obtaining consumer input into new KPIs, rolling out two additional QM web based training modules for staff, further refining the KPI dashboard format, and analyzing & utilizing data trends/patterns to make program decisions or changes.

Appendix A Community Behavioral Health Outcomes Framework



Draft

Appendix B DBHDD Quality Management Work Plan

Goal 1: Develop accurate, effective and meaningful performance indicators.

Tasks	Responsible Person	Target Completion Date	Status
Determine the criteria for developing the key performance indicators	Carol Zafiratos	June 2013	Completed
Identify and assess current performance indicators for value and applicability	Carol Zafiratos, Steve Holton, Eddie Towson	June 2013	Delayed but in process. Anticipated completion = August 2013
Collaborate with stakeholders using the identified criteria to develop key performance indicators	Program Quality Councils	July 2013	In process and ongoing
Develop and implement data collection plans for KPIs (identify responsible persons for data entry, collection, reporting, etc)	Carol Zafiratos, Steve Holton, Eddie Towson	August 2013	

Goal: 2 Educate stakeholders regarding QM (includes staff, providers and ultimately individuals and families).

Tasks	Responsible Person	Target Completion Date	Status
Update the current QM Training Plan and ensure inclusion of training for hospitals, CBH and DD – see Appendix L for current plan	Carol Zafiratos and Training Department	June 2013	Delayed until September 2013
Continue development of web based training materials – three additional modules	Carol Zafiratos and Training Department	December 2013	
Develop and implement methodology to evaluate the effectiveness of the training	Carol Zafiratos and Training Department	December 2013	

Goal: 3 Assess and improve the effectiveness of the QM system and its various components.
This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Implement the EQC approved outcomes framework (identify/revise KPIs as applicable, develop a data definition/collection plan for each measure and implement data collection).	Program Quality Council Chairpersons	June 2013	Draft outcomes framework = completed for CBH and a DBHDD wide data definition document in draft format. KPI review will begin in August 2013.
Assess achievement levels of quality goals	Program Quality Council Chairpersons	March 2014	
Assess performance indicator achievement against target thresholds	Program Quality Council Chairpersons	March 2014	
Modify QM system and/or components as needed	Program Quality Council Chairpersons	March 2014	

Goal 4: Integrate QM Data Systems (have access to the data needed that is compatible with the hospital, community BH and community DD systems and which follows an individual and the services they receive across their lifetime, as applicable). This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Perform a comprehensive QM data management needs assessment	Director of IT and Carol Zafiratos, Steve Holton and Eddie Towson	January 2014	
Define and develop data sharing partnerships/agreements with other agencies (DCH, DJJ, DOE, DPH, DAS, etc)	DBHDD Leadership representative(s) [COO & Director of IT]	July 2014	
Create a QM information management plan (i.e.: policy and procedure development)	Director of IT	July 2014	
Develop a RFP to build a DBHDD Enterprise Data Systems (EDS)	Director of IT	July 2014	
Develop the DBHDD EDS	Director of IT	2015	
Evaluate the effectiveness and	Director of IT, Carol	2016	

efficiency of the newly created system	Zafiratos, Steve Holton and Eddie Towson		
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Appendix C Hospital System Quality Management Work Plan

Goal 1: Develop accurate, effective and meaningful performance indicators.

Tasks	Responsible Person	Target Completion Date	Status
Determine the criteria for developing the key performance indicators	Carol Zafiratos	June 2013	Completed
Identify and assess current performance indicators for value and applicability	Steve Holton, Dr. Risby, Carol Zafiratos	June 2013	Completed
Modify KPIs, as appropriate	Hospital System Quality Council	July 2013	Completed
Develop and implement data collection plans for KPIs (identify responsible persons for data entry, collection, reporting, etc)	Steve Holton and Carol Zafiratos	August 2013	Completed

Goal 2: Educate stakeholders regarding QM (includes staff, providers and ultimately individuals and families).

Tasks	Responsible Person	Target Completion Date	Status
Update the current QM Training Plan and ensure inclusion of training for hospitals – see Appendix J for current plan	Carol Zafiratos, Steve Holton and Training Department	June 2013	Delayed until September 2013
Identify desired knowledge, skills, abilities and behaviors for Hospital Quality Managers	Director of Hospital System Quality Management	August 2013	
Assess training needs of QMs.	Director of Hospital System Quality Management	Sept 15, 2013	
Develop training plans and methodology for QMs.	Director of Hospital System Quality Management ,Carol Zafiratos and Training Department	Nov 1, 2013	

Goal 3: Assess and improve the effectiveness of the QM system and its various components.

Tasks	Responsible Person	Target Completion Date	Status
Set target values for Hospital System KPIs.	Dr. Emile Risby – Chair Hospital System Program Quality Council	June 2013	Completed
Each hospital creates their data definition/collection plans	Program Quality Council Chairpersons	March 2014	
Each hospital identifies and submits their KPIs (hospital level) and PI goals to the HSPQC	Program Quality Council Chairpersons	March 2014	
Hospitals update analyses and begin to prepare reports for Hospital System QC (Quality Management effectiveness review meeting scheduled for March 2014).	Program Quality Council Chairpersons	March 2014	

Goal 4: Integrate QM Data Systems (have access to the data needed that is compatible with the hospital, community BH and community DD systems and which follows an individual and the services they receive across their lifetime, as applicable).

Tasks	Responsible Person	Target Completion Date	Status
Organize a Hospital System information management committee	Director of Hospital System Quality Management	July 15, 2013	Completed
Develop methodology for performing IM needs assessment	Chair of Information Management Committee & Director of Hospital System Quality Management	September 1, 2013	
Perform needs assessment in hospitals and analyze results	Chair of Information Management Committee & Director of Hospital System Quality Management	November 1, 2013	
Set priorities for IM needs and	Chair of Information	December 1, 2013	

communicate priorities to OIT, as appropriate.	Management Committee & Director of Hospital System Quality Management		
Develop Hospital System IM plan	Chair of Information Management Committee & Director of Hospital System Quality Management	December 31, 2013	

Appendix D Community Behavioral Health Quality Management Work Plan

Goal 1: Develop accurate, effective and meaningful performance indicators.

Tasks	Responsible Person	Target Completion Date	Status
Distribute Performance Measure Evaluation Tool (PMET) to CBH committee members	Carol Zafiratos	July 2013	Completed
Utilize criteria (from PMET) to assess current KPI's	Chris Gault and CBH Program Staff	September 2013	
Use PEMT and develop new KPI's as indicated	Chris Gault and CBH Program Staff	October 2013	
Make recommendations regarding the infrastructure that is needed to ensure data integrity and follow up for new KPIs	Chris Gault and CBH Program Staff	October 2013	
Collaborate with stakeholders to review and provide feedback on new KPI's	Chris Gault and CBH Program Staff	October 2013	
Develop data collection plans for new KPIs (identify responsible persons for data entry, collection, reporting, etc.)	Chris Gault and CBH Program Staff	November 2013	
Implement data collection plans for new KPIs	Chris Gault and CBH Program Staff	January 2014	
Initiate provider based data integrity reviews	Resources need to be identified	March 2014	

Goal: 2 Educate stakeholders regarding QM (includes staff, providers and ultimately individuals and families).

Tasks	Responsible Person	Target Completion Date	Status
Develop and implement recommendations for the first three quality management related training modules for State and Regional Office BH staff	CBH PQC and Carol Zafiratos	Start Date = September 2013 Completion Date = January 2014	Memo distributed to senior leadership in July. First module to be released in August 2013.
Once approved implement the training recommendations and monitor compliance for state staff	CBH Program Managers	Start Date = October 2013	

Develop a QM training plan for providers	CBH PQC, Chris Gault and Carol Zafiratos	January 2014	
Develop a QM training plan for individuals served and families	CBH PQC, Chris Gault and Carol Zafiratos	March 2014	

Goal: 3 Assess and improve the effectiveness of the QM system and its various components.
This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Using the PMT, annually review all KPI's for efficiency and effectiveness	CBH PQC	January 2015	

Goal 4: Integrate QM Data Systems (have access to the data needed that is compatible with the hospital, community BH and community DD systems and which follows an individual and the services they receive across their lifetime, as applicable). This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Make recommendations based upon KPI selection for future data needs	CBH PQC through Chris Gault	December 2013 and ongoing	

Appendix E Developmental Disabilities Quality Management Work Plan

Goal 1: Assess and improve the effectiveness of the QM System and its various components that assures quality person-centered supports and services for individuals with developmental disabilities. **Goal 2:** Develop accurate and meaningful performance indicators.

Tasks	Responsible Person	Target Completion Date	Status
Documentation review (i.e. relevant policies and procedures, recent CMS Waiver changes, DOJ Settlement Agreement, etc.)	Director of DD Quality Management and Contractor	06/30/13	Completed
Assessment of current data collection methods	Director of DD Quality Management and Contractor	07/31/13	
Assessment of current data utilization	Director of DD Quality Management and Contractor	07/31/13	
Interview Central and Regional Office staff to identify capabilities of quality practitioners	Director of DD Quality Management and Contractor	07/31/13	
Conduct Stakeholder interviews to determine capabilities of quality practitioners	Director of DD Quality Management and Contractor	07/31/13	
Conduct Focus Groups with targeted stakeholders to collect information on strengths, benefits and opportunities for improvement	Director of DD Quality Management and Contractor	07/31/13	
Conduct Interviews with service provider and service coordination staff	Director of DD Quality Management and Contractor	07/31/13	
Conduct comparison of requirements generated by DBHDD to CMS and DOJ requirements	Director of DD Quality Management and Contractor	07/31/13	
Establish QI Council workgroup to design new	Director of DD Quality	07/31/13	

QM system with participation from DD Advisory Council	Management and Contractor		
Develop report describing the status of the "as is" system	Director of DD Quality Management and Contractor	08/01/13	
Develop recommendations for improvements to Georgia's quality system	Director of DD Quality Management and Contractor	08/01/13	
As part of Goal 1 DD will establish accurate, effective, and meaningful performance indicators for DD Services and DD Providers	Director of DD Quality Management and Contractor	08/15/13	
Finalize measurements	Director of DD Quality Management and Contractor	09/15/30/13	
Develop comprehensive description of redesign for statewide DD QM system	Director of DD Quality Management and Contractor	10/01/13	

Goal 2: Educate Stakeholders regarding QM (including staff, providers, and individuals and families)

Tasks	Responsible Person	Target Completion Date	Status
Identify core knowledge and skill requirements for each quality role identified.	Director of DD Quality Management and Dept Director of QM	08/31/13	
Review and analyze the instructional system/knowledge and basic skill topics with DBHDD Staff and quality councils.	Director of DD Quality Management and Dept Director of QM	08/31/13	
Develop materials and methods for learning management and curriculum development	Director of DD Quality Management and Dept Director of	09/30/13	

	QM		
Create DD training program draft and review with DBHDD Staff and Quality Councils	Director DD Quality Management	10/31/13	
Finalize training program with input from Quality Councils and Advisory Council	Director DD Quality Management	11/15/13	
Train staff and stakeholders on new DD QM System	Director DD Quality Management and Contractor	12/15/13	
Draft a manual which includes the following sections:	Director of DD Quality Management and Contractor	12/15/13	
• QM and improvement requirements section			
• Roles and responsibilities section			
• Guidance on joint agency collaboration			
• Reporting requirements			
• Tools for data collection and analysis			
Review drafts of each section with DBHDD staff and QI Councils and Advisory Council	Director of DD Quality Management	12/31/13	

Goal 3: Ensure that individuals with DD transitioned out of state hospitals to receive high quality services and to achieve life goals in community.

Tasks	Responsible Person	Target Completion Date	Status
Develop the follow-up and monitoring process	Joseph Coleman, Director of	04/01/13 6/5/13	Completed Revisions completed to

	Transitions DD		incorporate full review of findings/reports by Central Office
Finalize the audit tool	Joseph Coleman, Director of Transitions DD	04/01/13 6/5/13	Completed Revisions completed to utilize full monitoring tool developed by DOJ
Identify the reviewers/auditors	Joseph Coleman, Director of Transitions DD	04/01/13	Completed
Create, hire, train Regional DD Transition Quality Review Team	Joseph Coleman, Director of Transitions DD, and Rose Wilcox. Director of Training and Education DD	7/1/13	Training by DOJ Consultants scheduled for 6/21, 6/25, and 6/26/13
Decide the process of data collection, reporting, and correcting problems identified	Joseph Coleman, Director of Transitions DD	6/10/13	Completed
Review quality of transition for 79 individuals who have transitioned out of state hospitals as of July 1, 2012	Joseph Coleman, Director of Transitions DD	06/20/13	Ongoing
Pre-transition review of Provider capacity to ensure quality care for 40 individuals whose planned May/June transitions were postponed until after July 1, 2013	Joseph Coleman, Director of Transitions DD	06/25/13	Ongoing
Review and revise the current transition process to develop a comprehensive process / plan	Joseph Coleman, Director of Transitions DD	7/1/13	Revisions ongoing to include pre and post transition reviews

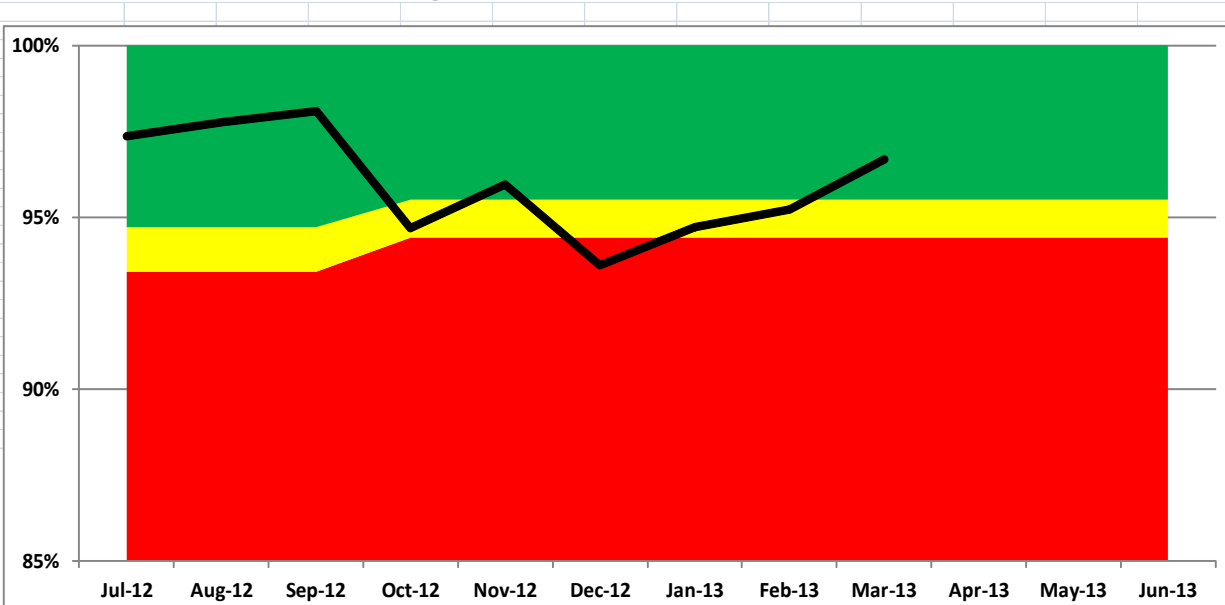
Goal 4: Integrate QM Data Systems in a manner which is compatible with Department data systems (Hospital, Community BH and Community DD) which will allow Division to follow an individual and their services across their lifetime. This is a multi-year goal.

Tasks	Responsible Person	Target Completion	Status
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		Date	
Develop Division DD information management committee	Director of DD Quality Management	08/01/13	
Assessment current information management systems methods for collection and utilization	Director of DD Quality Management and Division Data Manager	08/01/13	
Set priorities for IM needs and work with OIT to address those needs as appropriate.	Director of DD Quality Management and Division Data Manager	10/01/13	
Include development of new DD case management system in the Department's RFP for an Administrative Service Organization (ASO)	Director of DD Quality Management	10/01/13	
Work with ASO to develop and test new system	Director of DD Quality Management and Vendor	08/01/14	
Train end users on new system	Director of DD Quality Management and Vendor	10/01/14	
Transition data from old case management system to new system	Director of DD Quality Management and Vendor	12/31/14	

Appendix F Hospital System KPI Dashboards

Continuing Care Plan Created (Overall)



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	515	567	513	553	449	497	502	497	526	0	0	0
Denominator	529	580	523	584	468	531	530	522	544	0	0	0
Rate	97%	98%	98%	95%	96%	94%	95%	95%	97%	#N/A	#N/A	#N/A
Quarterly Average	98%			95%			96%					

MEASURE DEFINITION AND EXPLANATION

Measure definition: Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan that contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.

Measure explanation: This measure is a nationally standardized performance measure for behavioral health organizations, reported to The Joint Commission through our partner, NRI, on a quarterly basis. The data are for people who were treated in adult mental health inpatient programs only. The colored bands represent zones that indicate level of acceptability of scores and are based The Joint Commission "Target Rates" published quarterly, 4 to 5 months after the quarter ends. The most recent rates published are used as guides for current data. The red area of the graph indicates the area that is below The Joint Commission's Target Range. The Joint Commission changed the target range in October 2012 from 93.4% to 94.4%.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.
Included Populations: NA
Excluded Populations: None

Denominator: Psychiatric inpatient discharges. Included Populations: Patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders. Excluded Populations: The following cases are excluded: • Patients who expired • Patients with an unplanned departure resulting in discharge due to elopement or failing to return from leave • Patients or guardians who refused aftercare • Patients or guardians who refused to sign authorization to release information • Patients discharged to another unit within the same hospital

COMMENTS AND/OR ANALYSIS PER QUARTER

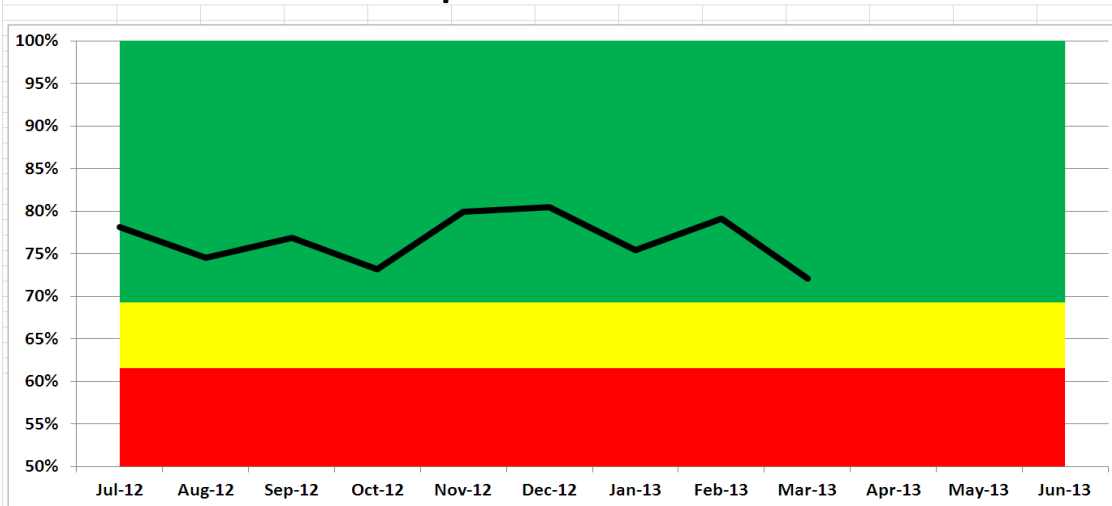
April-June 2013 Analysis

At the time of the creation of this report, several hospitals had not yet submitted all the data for this measure for this quarter. Since these data are a compilation of all hospital data, it would be inappropriate to report partial information at this time.

January-March 2013 Analysis

Issues that led to the decline reflected in December 2012's 94% (which was just below the lower target of 94.4%) were identified and corrected in January 2013. The result is represented in this quarter's reporting of compliance steadily increasing for all three months.

Client Perception of Outcome of Care



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	139	146	123	117	139	140	123	140	168	0	0	0
Denominator	178	196	160	160	174	174	163	177	233	0	0	0
Rate	78%	74%	77%	73%	80%	80%	75%	79%	72%	#N/A	#N/A	#N/A
Quarterly Average	76%			78%			75%					

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of clients at discharge or at annual review who respond positively to the outcome domain on the Inpatient Consumer Survey.

Measure explanation: This measure shows client responses to the following questions:

- *I am better able to deal with crisis.
- *My symptoms are not bothering me as much.
- *I do better in social situations.
- *I deal more effectively with daily problems.

(Source: NRI) The determination of the line where the red/yellow areas of the graph meet is based on the national average published by NRI for May 2012 through May 2013, less one standard deviation. (Data collection for surveys were started state-wide in February 2012.)

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of clients who respond positively to the outcome domain

Denominator: Number of clients completing at least 2 items in the outcome domain Included populations: Clients who were discharged during the period and completed at least 2 questions in the domain. Only clients served in programs associated with Adult Mental Health are surveyed.

COMMENTS AND/OR ANALYSIS PER QUARTER

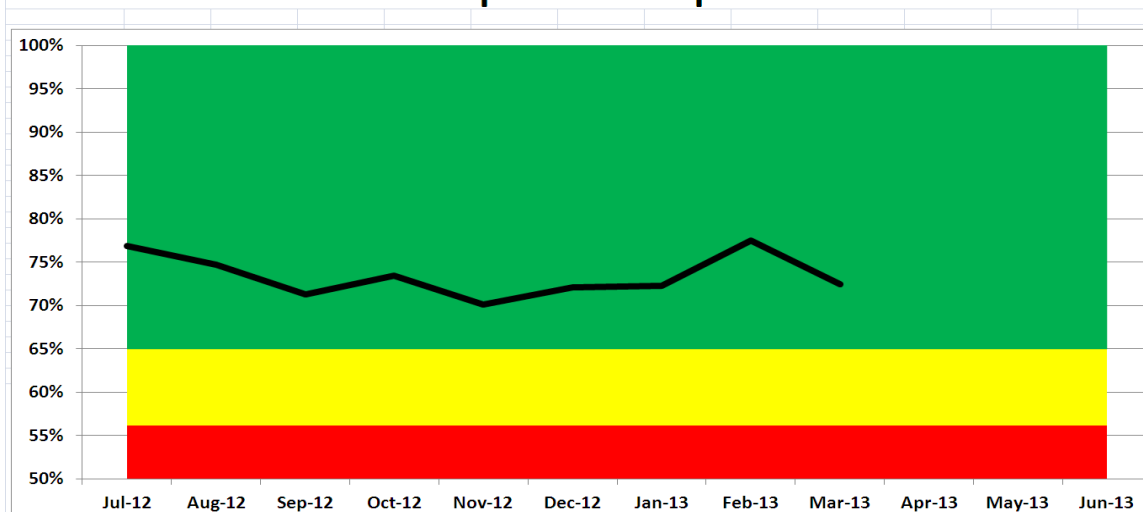
April-June 2013 Analysis

At the time of the creation of this report, several hospitals had not yet submitted all the data for this measure for this quarter. Since these data are a compilation of all hospital data, it would be inappropriate to report partial information at this time.

January-March 2013 Analysis

The DBHDD Hospital System facilities have consistently scored higher than the baseline established on the basis of the national averages for the same survey tool. The Quality Management departments are looking at ways to improve the consistence and timeliness of reporting and the consistency and quality of the methods of administration of the survey instruments.

Client Perception of Empowerment



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	136	109	62	105	122	124	120	134	166	0	0	0
Denominator	177	146	87	143	174	172	166	173	229	0	0	0
Rate	77%	75%	71%	73%	70%	72%	72%	77%	72%	#N/A	#N/A	#N/A
Quarterly Average	75%			72%			74%					

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of clients at discharge or at annual review who respond positively to the empowerment domain on the Inpatient Consumer Survey.

Measure explanation: This measure shows client responses to the following questions:

*I had a choice of treatment options.

*My contact with my doctor was helpful.

*My contact with nurses and therapist was helpful.

(Source: NRI) The determination of the line where the red/yellow areas of the graph meet is based on the national average published by NRI for May 2012 through May 2013, less one standard deviation. (Data collection for surveys were started state-wide in February 2012.)

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of clients who respond positively to the empowerment domain

Denominator: Number of clients completing at least 2 items in the empowerment domain Included populations: Clients who were discharged during the period and completed at least 2 questions in the domain. Only clients served in programs associated with Adult Mental Health are surveyed.

COMMENTS AND/OR ANALYSIS PER QUARTER

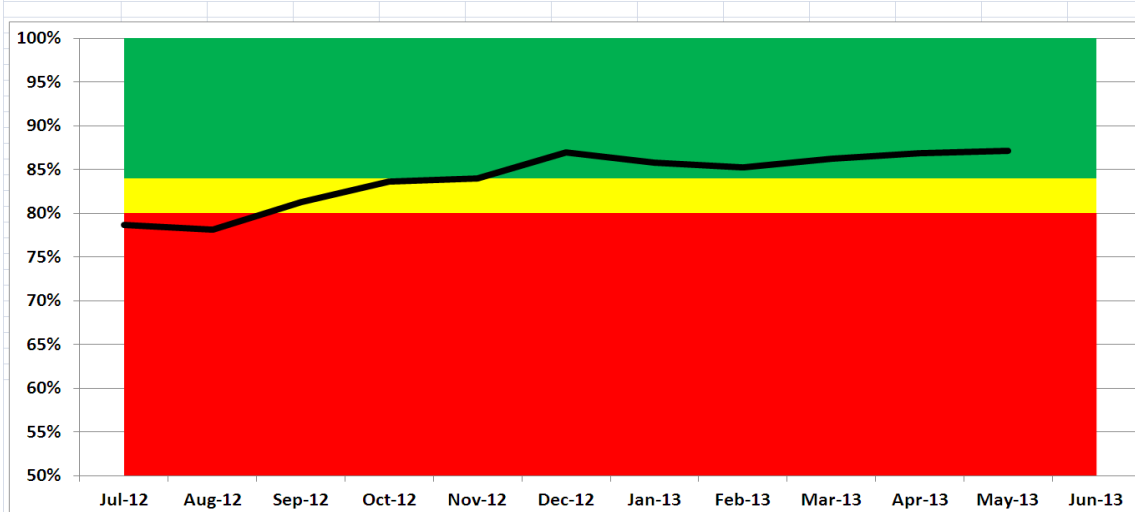
April-June 2013 Analysis

At the time of the creation of this report, several hospitals had not yet submitted all the data for this measure for this quarter. Since these data are a compilation of all hospital data, it would be inappropriate to report partial information at this time.

January-March 2013 Analysis

The DBHDD Hospital System facilities have consistently scored higher than the baseline established on the basis of the national averages for the same survey tool. The Quality Management departments are looking at ways to improve the consistence and timeliness of reporting and the consistency and quality of the methods of administration of the survey instruments.

Individual Recovery Plan Audit - Quality Measure



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	2113	2234	2428	2065	1669	2183	2232	1996	2270	2125	2220	0
Denominator	2687	2858	2986	2470	1988	2510	2602	2342	2632	2447	2547	0
Rate	79%	78%	81%	84%	84%	87%	86%	85%	86%	87%	87%	#N/A
Quarterly Average	79%			85%			86%			87%		

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of positive responses to the Individualized Recovery Plan audit's questions on "Quality."

Measure explanation: Chart audit focusing on the quality and internal-consistency of the Individualized Recovery Plan. Audit began January 2012.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Total number of "Yes" responses to questions 2-20 on the IRP audit

Denominator: Total number of "No" responses to questions 2-20 on the IRP audit

COMMENTS AND/OR ANALYSIS PER QUARTER

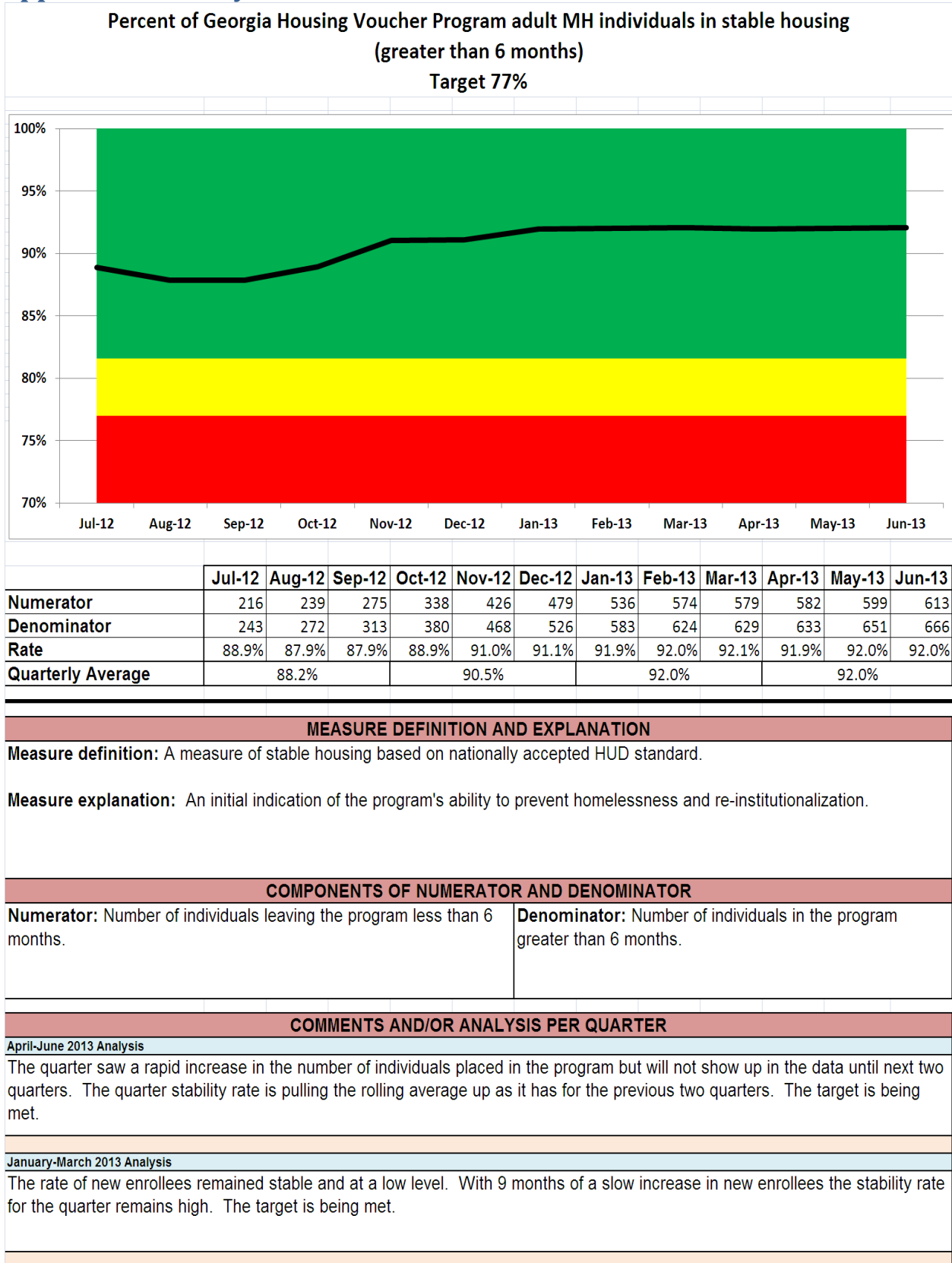
April-June 2013 Analysis

The gradual improvements reflected in these data indicate that the current strategy has been effective.

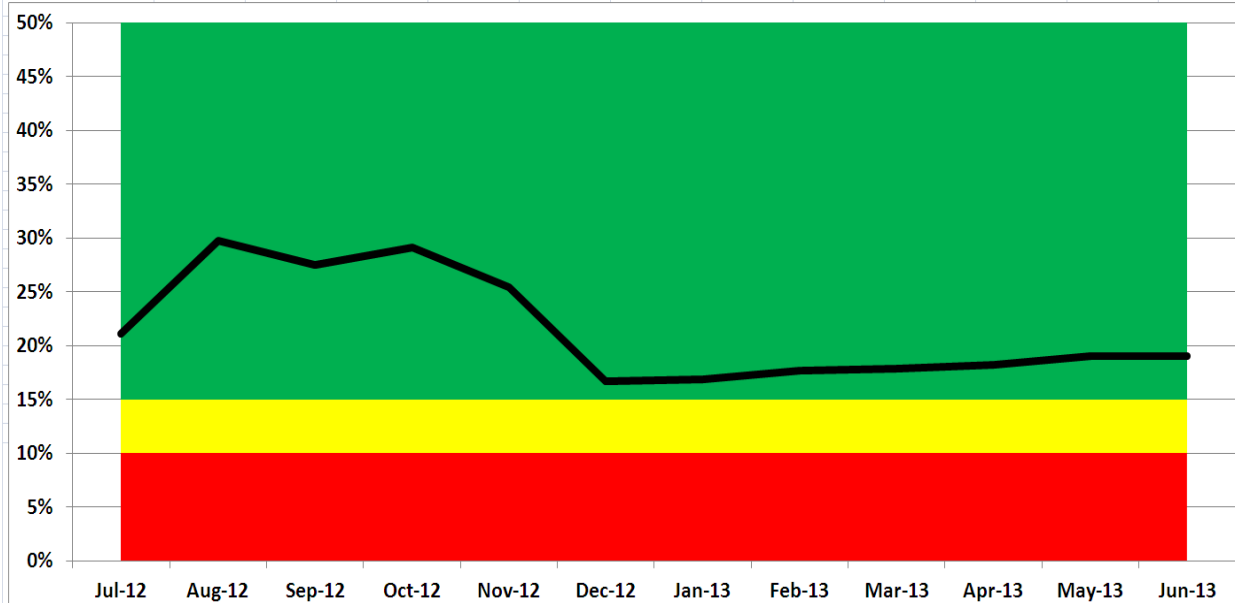
January-March 2013 Analysis

A gradual overall trend upwards (positive) is being achieved, even though the timeframe of January-March appears to be relatively flat. It appears the training and emphasis placed on the measure had an overall positive affect on the averages.

Appendix G CBH System KPI Dashboards



Percent of Georgia Housing Voucher Program adult MH individuals who left stable housing under unfavorable circumstances and have been reengaged and reassigned vouchers
Target 10%



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	8	14	14	16	16	15	16	18	20	22	27	27
Denominator	38	47	51	55	63	90	95	102	112	121	142	142
Rate	21.1%	29.8%	27.5%	29.1%	25.4%	16.7%	16.8%	17.6%	17.9%	18.2%	19.0%	19.0%
Quarterly Average	26.5%			22.6%			17.5%			18.8%		

MEASURE DEFINITION AND EXPLANATION

Measure definition: A measure to determine negative program leavers in order to divert them from homelessness or other more expensive systems of care.

Measure explanation: Reinforces the notion that recovery is not a straight line and that reengagement after initial failure is an important program component.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of individuals that left the program under negative circumstances that reentered the program.

Denominator: Number of individuals that left the program under negative circumstances.

COMMENTS AND/OR ANALYSIS PER QUARTER

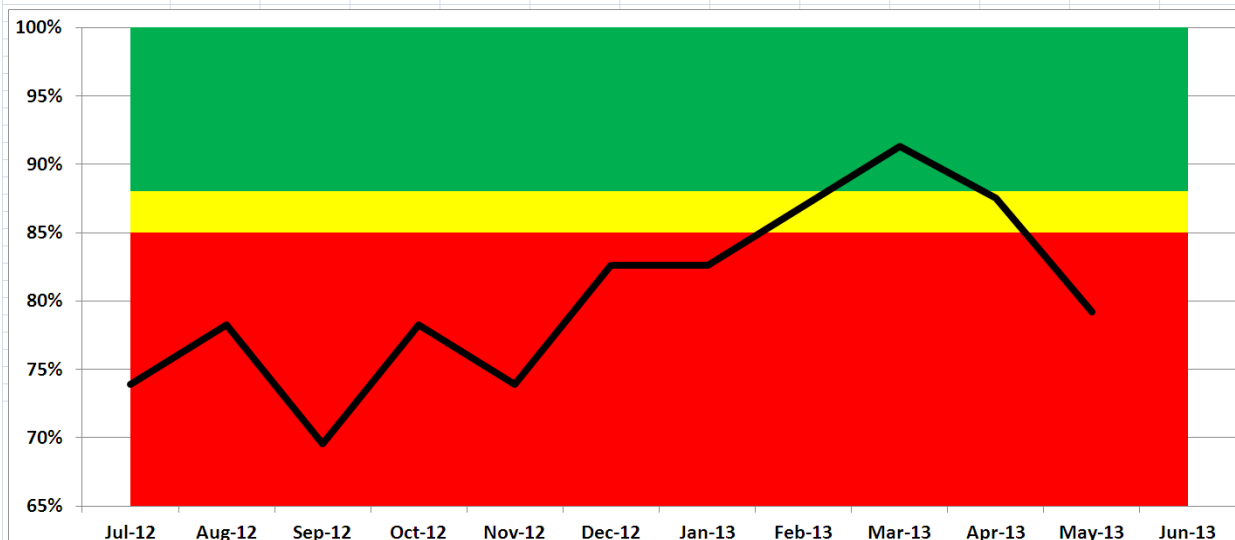
April-June 2013 Analysis

There is a slight upward trend in the reengagement rate unless variability as the portfolio ages with more opportunities for providers to work with their clients knowing the program has the ability to continue the support.

January-March 2013 Analysis

A floor seems to be established with some consistency in the rate of reengagement.

**Percent of adult MH supported employment providers that meet a caseload average of employment specialist staff to consumer (ratio 20:1)
Target (85%) or more**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	17	18	16	18	17	19	19	20	21	21	19	0
Denominator	23	23	23	23	23	23	23	23	23	24	24	0
Rate	73.9%	78.3%	69.6%	78.3%	73.9%	82.6%	82.6%	87.0%	91.3%	87.5%	79.2%	#N/A
Quarterly Rate	73.9%			78.3%			87.0%			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of adult MH supported employment providers that meet a caseload average of employment specialist staff to consumer ratio 20:1.

Measure explanation: The percent of adult MH contracted supported employment providers that met a mental health caseload average of 20 to 1 or less on the last day of the calendar month.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of contracted providers with a consumer to staff ratio of 20:1 or below on the last day of the month.

Denominator: Number of contracts DBHDD Community Mental Health holds for Supported Employment.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2013 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, this measure will end and a new one will start. The new measure will be to examine a 1:15 to 1:20 ratio, rather than 1:0 to 1:20. During this quarter, providers received training and communication in regards to how important this measure is and how it relates to Fidelity in the IPS Fidelity Model.

Percent of unduplicated individuals who had 1st contact with a competitive employer within 30 days of enrollment
Target (50%) or more



	Apr-Jun 2012	Jul-Sep 2012	Oct-Dec 2012	Jan-Mar 2013
Numerator	42	100	55	56
Denominator	55	142	81	84
Rate	76.4%	70.4%	67.9%	66.7%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of unduplicated individuals who had 1st contact with a competitive employer within 30 days of enrollment.

Measure explanation: The percent of individuals meeting settlement criteria that were enrolled during the quarter that had contact with a potential employer in the open job market within 30 days of enrolling in supported employment services.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of settlement criteria consumers who started Supported Employment services during the quarter and who had first contact with a competitive employer within 30 days.

Denominator: Number of settlement criteria consumers who started Supported Employment services during the quarter.

COMMENTS AND/OR ANALYSIS PER QUARTER

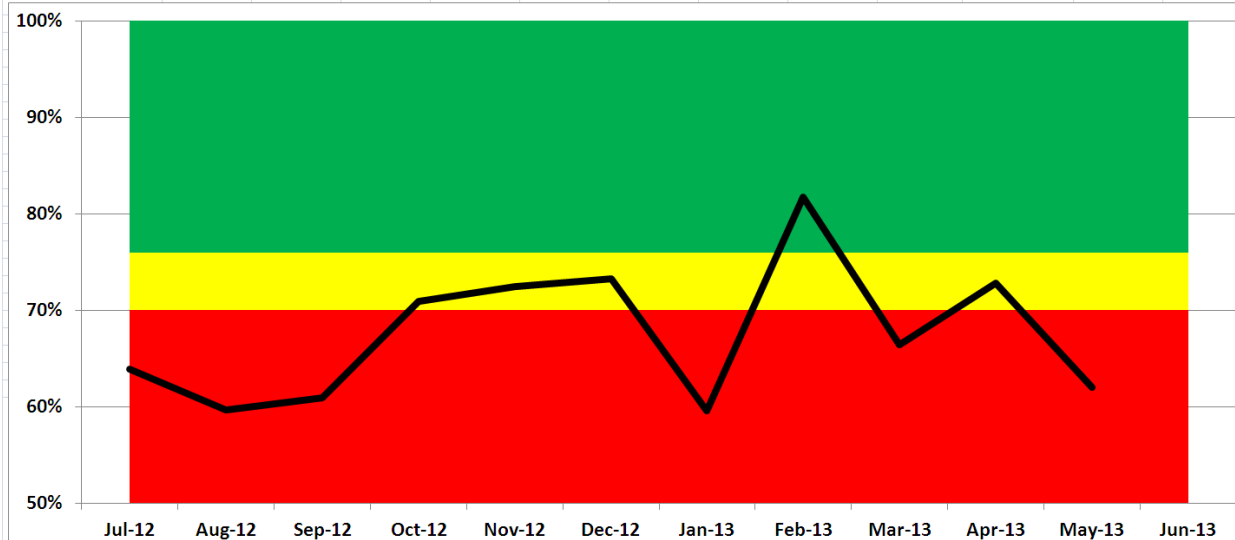
April-June 2013 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, the target for this measure will be 75%.

**Percent of Assertive Community Treatment consumers who are enrolled
within 3 days of referral
Target (70%) or more**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	69	62	56	134	176	137	84	94	101	83	80	0
Denominator	108	104	92	189	243	187	141	115	152	114	129	0
Rate	63.9%	59.6%	60.9%	70.9%	72.4%	73.3%	59.6%	81.7%	66.4%	72.8%	62.0%	#N/A
Quarterly Rate	61.5%			72.2%			68.4%			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of ACT consumers who are enrolled within three days of referral.

Measure explanation: The percent of ACT consumers enrolled during the month that waited three days or less since their date of referral to ACT services.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers enrolled during the month who were enrolled within 3 days of referral date.

Denominator: Total number of consumers enrollments (aka consumers who started services) during the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2013 Analysis

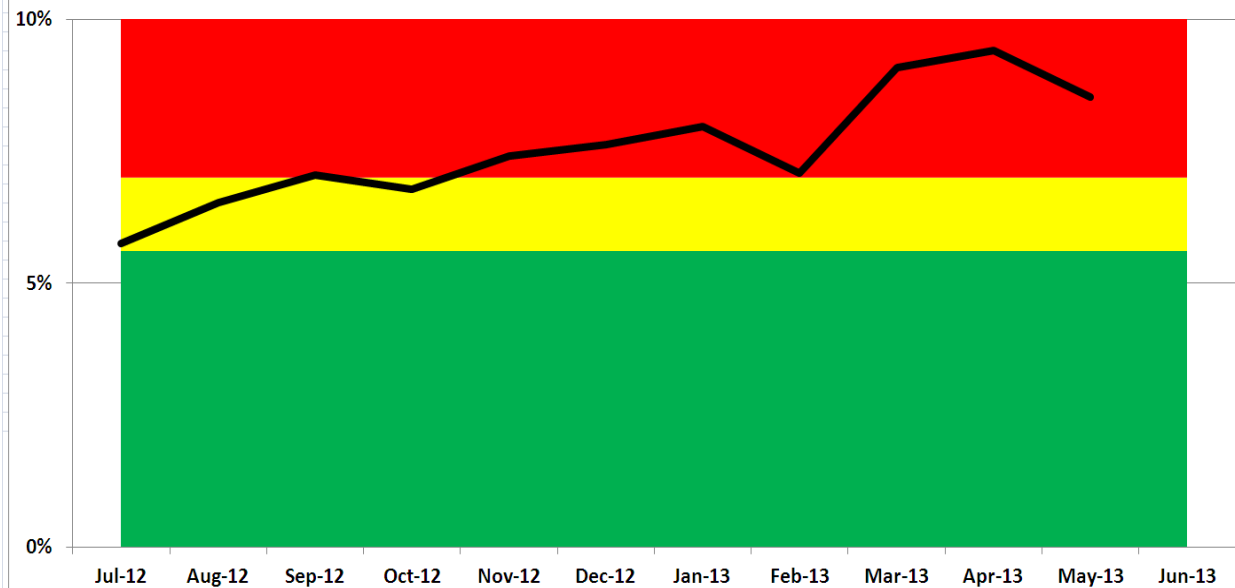
Data collection and analysis not complete as of the writing of this report.

This key performance indicator ends June 2013 and is replaced with a new indicator: "Percent of consumers who are received into ACT services within three days."

January-March 2013 Analysis

Although there has been an overall increase in percentage over the past one and a half years, this quarter displayed varying numbers. Providers of ACT services indicated varying definitions of "enrollment." Therefore, a determination was made to end this indicator and create a new indicator starting in July 2013 that more clearly defines the intent of the measure (ensuring ACT teams are responsive to consumers referred to the service).

**Percent of Assertive Community Treatment consumers admitted to a
Psychiatric Hospital within the past month
Target (7%) or less**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	102	111	99	81	88	97	113	100	121	138	127	0
Denominator	1771	1700	1406	1194	1188	1273	1418	1410	1333	1468	1489	0
Rate	5.8%	6.5%	7.0%	6.8%	7.4%	7.6%	8.0%	7.1%	9.1%	9.4%	8.5%	#N/A
Quarterly Rate	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of ACT consumers admitted to a Psychiatric hospital within the past month.

Measure explanation: The percent of consumers in ACT services for over thirty days that were admitted to a psychiatric hospital during the month.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers enrolled 30+ days and who were admitted to a Psychiatric Inpatient hospital during the month.

Denominator: Number of consumers enrolled on the last day of month MINUS the number of enrollments during month.

COMMENTS AND/OR ANALYSIS PER QUARTER

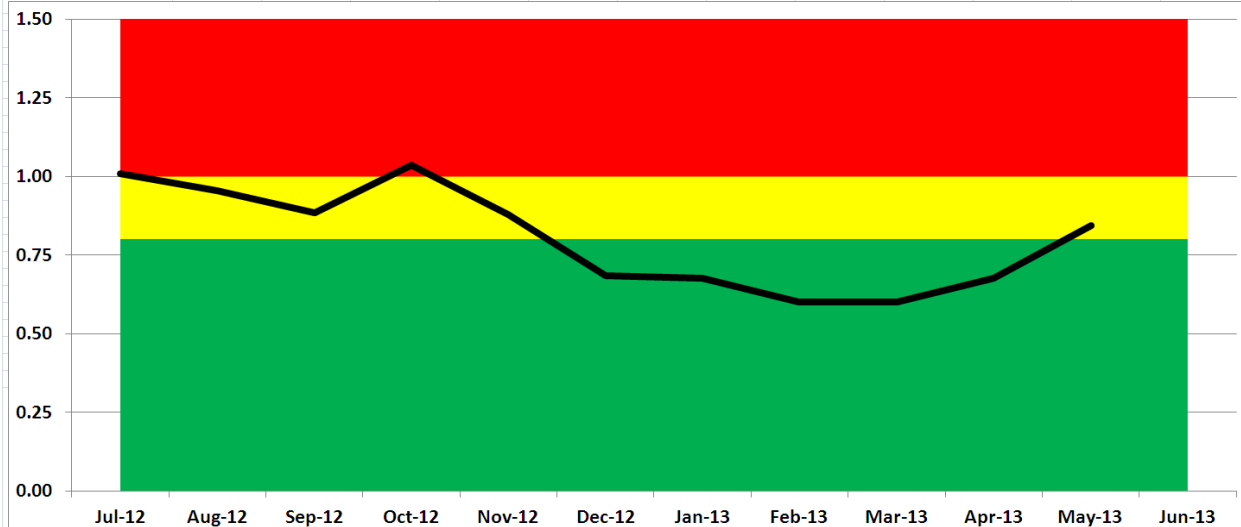
April-June 2013 Analysis

Data collection and analysis not complete as of writing of this report.

January-March 2013 Analysis

A slight upward trend in utilization was identified in this quarter. ACT teams indicated that many of their newer individuals in services were being admitted into the hospital for further stabilization.

Average # of jail/prison days utilized
(per enrolled Assertive Community Treatment consumer)
Target (1.0 day) or less



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	1786	1624	1459	1605	1499	1025	1104	975	940	1137	1457	0
Denominator	1771	1700	1652	1551	1708	1501	1635	1621	1569	1679	1729	0
Rate	1.008	0.955	0.883	1.035	0.878	0.683	0.675	0.601	0.599	0.677	0.843	#N/A
Quarterly Rate	0.874			0.707			0.578			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: ACT Program - Average number of jail/prison days utilized per enrolled consumer.

Measure explanation: The average number of days consumers (who have been in ACT services for over thirty days) spent in jail/prison during the month.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of jail days utilized for consumers in services 30+ days. **Denominator:** Number of discharges during month PLUS the number of consumers enrolled on the last day of month.

COMMENTS AND/OR ANALYSIS PER QUARTER

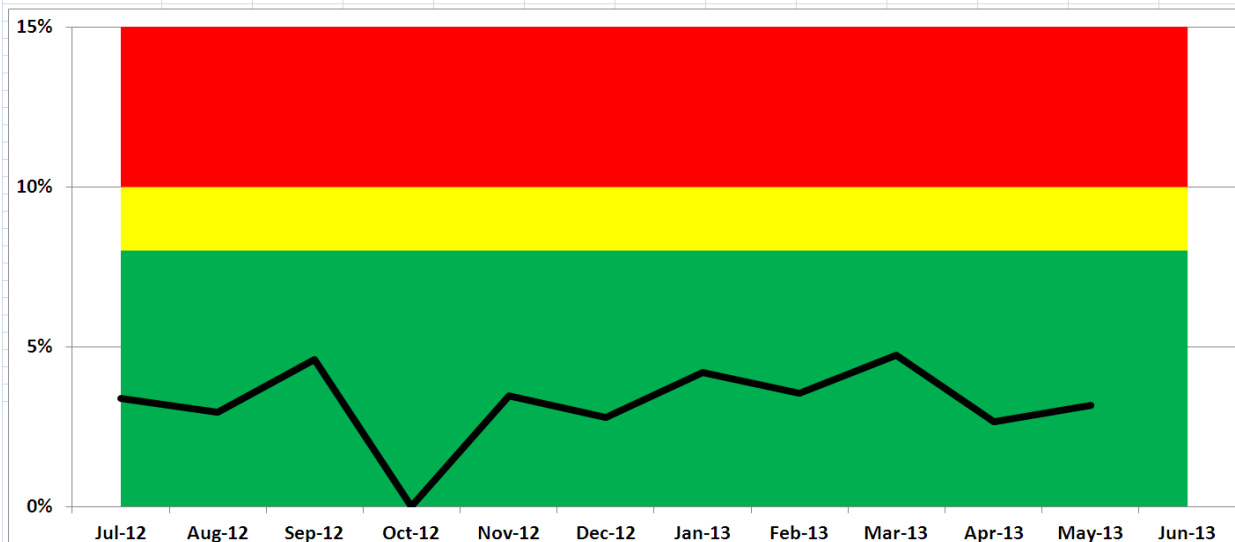
April-June 2013 Analysis

Data collection and analysis not complete as of the writing on this report.

January-March 2013 Analysis

A slight downward trend in jail utilization was noted in this quarter. Some ACT teams reported that some incarcerations were related to probation and parole violations of conditional release orders. Looking at data from the same time period for last year, it appears that there is a higher utilization in the summer months. Some ACT teams hypothesized that the warmer weather brought individuals outside more and small crimes like loitering, panhandling, etc. occur more often in the summer months.

**Percent of Intensive Case Management consumers with a
Psychiatric Inpatient Admission within the past month
Target (10%) or less**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	5	5	10	0	8	6	9	8	11	6	8	0
Denominator	148	170	217	207	231	215	215	225	233	227	252	0
Rate	3.4%	2.9%	4.6%	0.0%	3.5%	2.8%	4.2%	3.6%	4.7%	2.6%	3.2%	#N/A
Quarterly Rate	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of ICM consumers with a Psychiatric Inpatient Admission within the past month.

Measure explanation: The percent of consumers in ICM services for over thirty days that were admitted to a psychiatric hospital during the month.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers enrolled 30+ days and who were admitted to a Psychiatric Inpatient hospital during the month.

Denominator: Number of consumers enrolled on the last day of month MINUS the number of enrollments during the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2013 Analysis

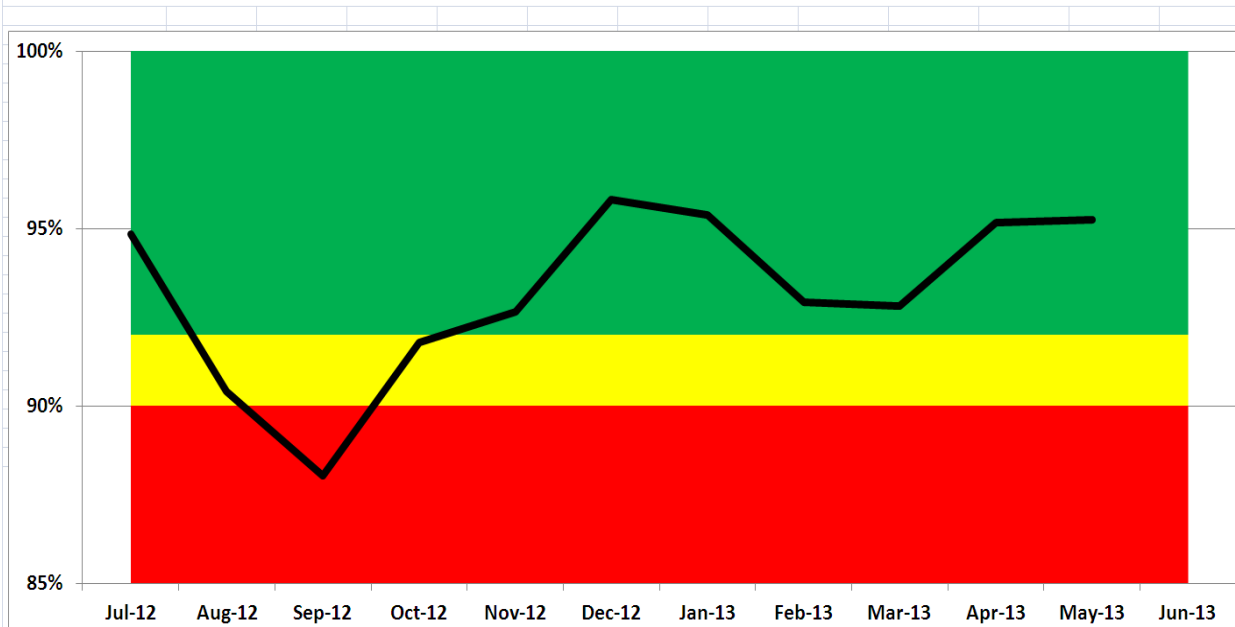
Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

March data indicated an increased number of individuals with psychiatric admissions. Providers attributed this spike to an increased number of persons served.

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, the target for this measure will be decreased to 5%. This target is currently being met.

**Percent of Intensive Case Management consumers housed
(non homeless) within the past month
Target (90%) or more**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	147	160	191	190	214	206	206	210	220	217	240	0
Denominator	155	177	217	207	231	215	216	226	237	228	252	0
Rate	94.8%	90.4%	88.0%	91.8%	92.6%	95.8%	95.4%	92.9%	92.8%	95.2%	95.2%	#N/A
Quarterly Rate	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of ICM consumers housed (non-homeless) within the past month.

Measure explanation: The percent of consumers in ICM services on the last day of the month that were not homeless.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers that were not homeless (on the street or in a shelter) on the last day of the month.

Denominator: Number of consumers enrolled on the last day of the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

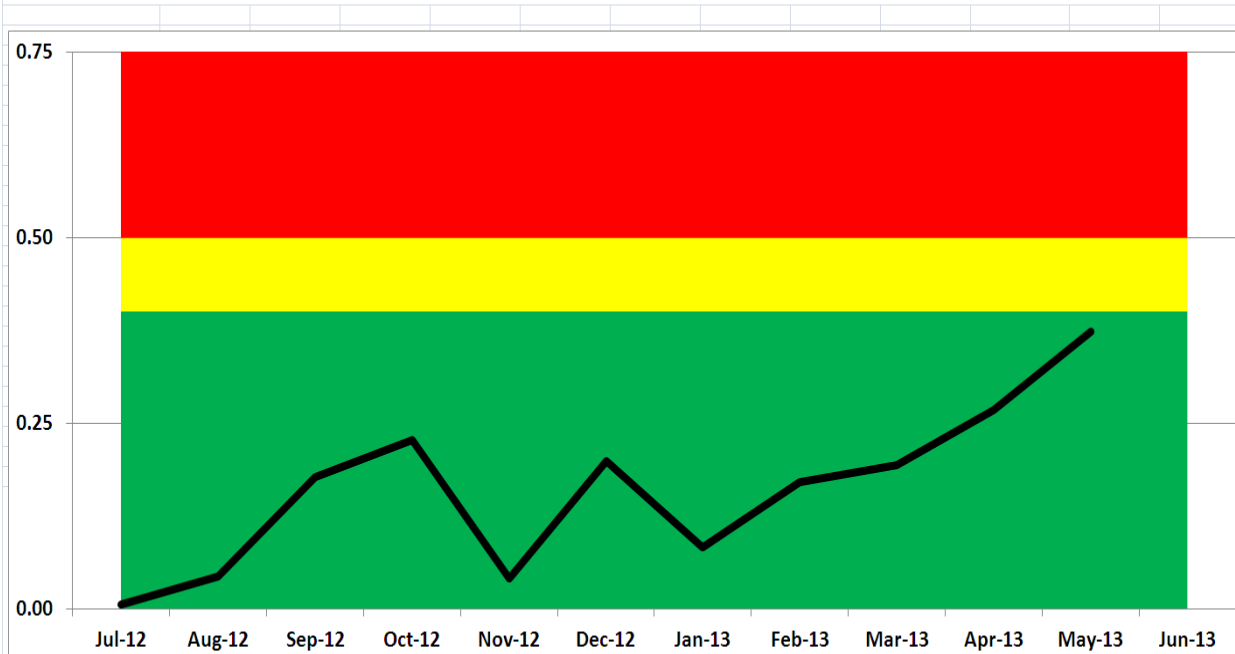
April-June 2013 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

Although data shows consistently high percentages throughout the quarter, Coalition meetings focused on resources available for individuals without income or with limited income. Target currently being met.

**Average # of jail/prison days utilized
(per enrolled Intensive Case Management consumer)
Target (0.50 days) or less**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	1	10	43	63	11	56	22	45	54	78	102	0
Denominator	199	232	242	278	267	281	268	265	279	291	273	0
Rate	0.005	0.043	0.178	0.227	0.041	0.199	0.082	0.170	0.194	0.268	0.374	#N/A
Quarterly Rate	0.199			0.396			0.376			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: Average number of jail/prison days utilized per enrolled consumer.

Measure explanation: The average number of days consumers (who have been in ICM services for over thirty days) spent in jail/prison during the month.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of jail days utilized for consumers in ICM services 30+ days.

Denominator: Number of discharges during the month PLUS number of consumers enrolled on the last day of the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2013 Analysis

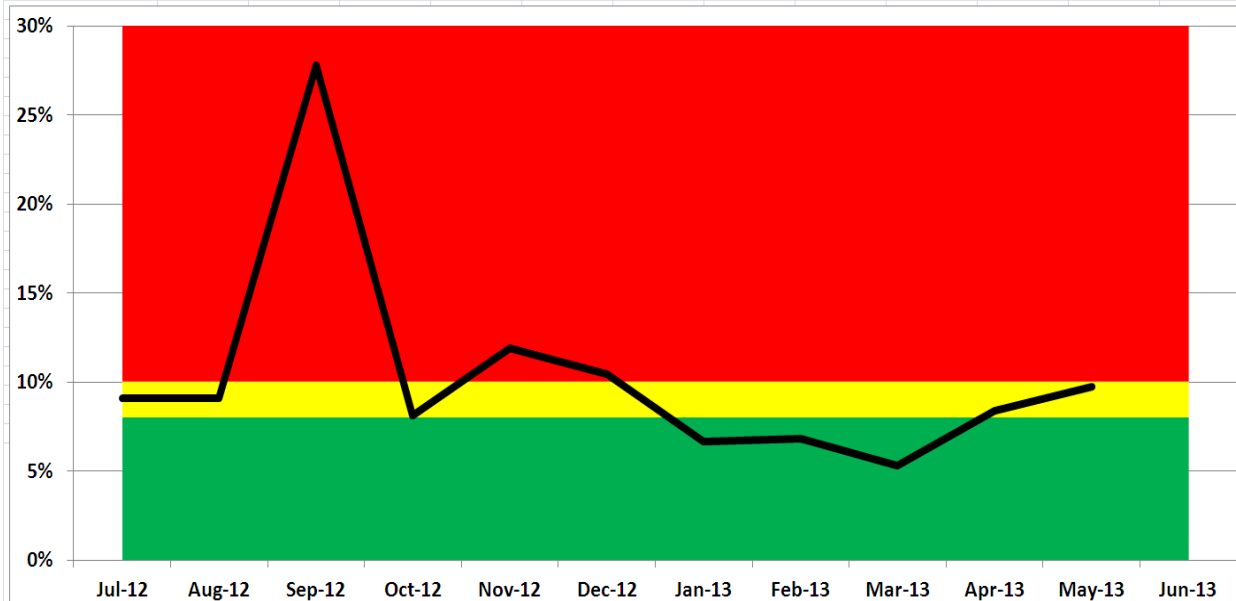
Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

Some variability in this quarter was attributed to one consumer who cycled in and out of jail.

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, the target for this measure will be decreased to 0.250 days or less. The target is currently being met.

**Percent of Community Support Team consumers with a Psychiatric Inpatient Admission
within the past month
Target (10%) or less**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	1	1	5	3	5	7	6	7	6	10	12	0
Denominator	11	11	18	37	42	67	90	103	113	119	123	0
Rate	9.1%	9.1%	27.8%	8.1%	11.9%	10.4%	6.7%	6.8%	5.3%	8.4%	9.8%	#N/A
Quarterly Rate	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of CST consumers with a Psychiatric Inpatient Admission within the past month.

Measure explanation: The percent of consumers in CST services for over thirty days that were admitted to a psychiatric hospital during the month.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers enrolled 30+ days and who were admitted to a Psychiatric Inpatient hospital during the month.

Denominator: Number of consumers enrolled on the last day of the month MINUS the number of enrollments during month.

COMMENTS AND/OR ANALYSIS PER QUARTER

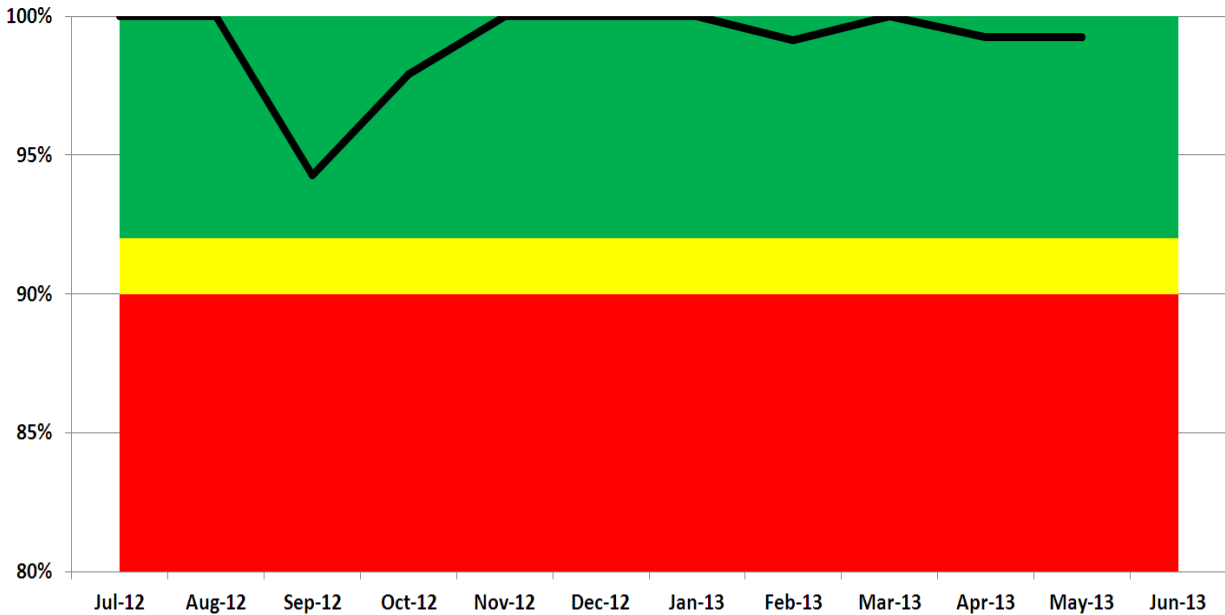
April-June 2013 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

The number of consumers served has steadily increased through the fiscal year. The percentages have reduced this quarter even though the number of individuals who have required psychiatric hospitalizations has remained steady. This is due to an increase in the number of individuals served.

**Percent of Community Support Team consumers housed
(non homeless) within the past month
Target (90%) or more**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	11	18	33	47	65	75	98	116	133	131	133	0
Denominator	11	18	35	48	65	75	98	117	133	132	134	0
Rate	100.0%	100.0%	94.3%	97.9%	100.0%	100.0%	100.0%	99.1%	100.0%	99.2%	99.3%	#N/A
Quarterly Rate	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of CST consumers housed (non-homeless) within the past month.

Measure explanation: The percent of consumers in CST services on the last day of the month that were not homeless.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers that were not homeless (on the street or in a shelter) on the last day of the month.

Denominator: Number of consumers enrolled on the last day of the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

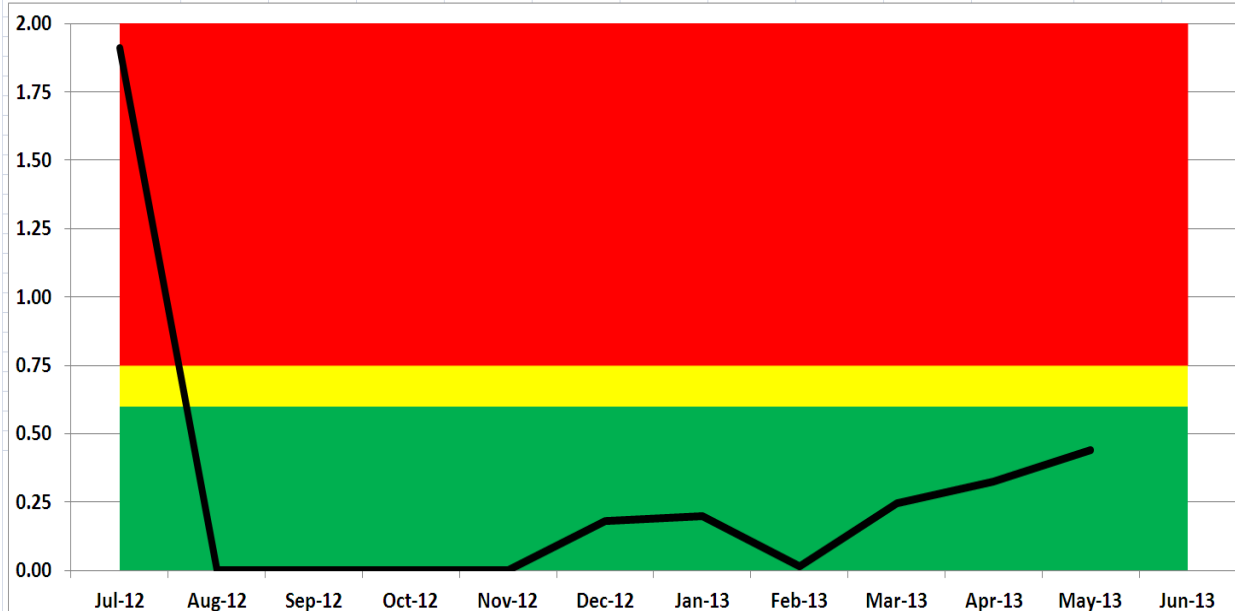
April-June 2013 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

During provider Coalition meetings, providers stated that many individuals live with family members and the need for housing is not an issue. Target currently being met.

Average # of jail/prison days utilized
(per enrolled Community Support Team consumer)
Target (0.75 days) or less



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	21	0	0	0	0	18	22	2	35	50	67	0
Denominator	11	18	46	58	80	99	110	125	142	154	152	0
Rate	1.909	0.000	0.000	0.000	0.000	0.182	0.200	0.016	0.246	0.325	0.441	#N/A
Quarterly Rate	0.457			0.159			0.396			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: Average number of jail/prison days utilized per enrolled consumer.

Measure explanation: The average number of days consumers (who have been in CST services for over thirty days) spent in jail/prison during the month.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of jail days utilized for consumers in CST services 30+ days.

Denominator: Number of discharges during the month PLUS the number of consumers enrolled on the last day of the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2013 Analysis

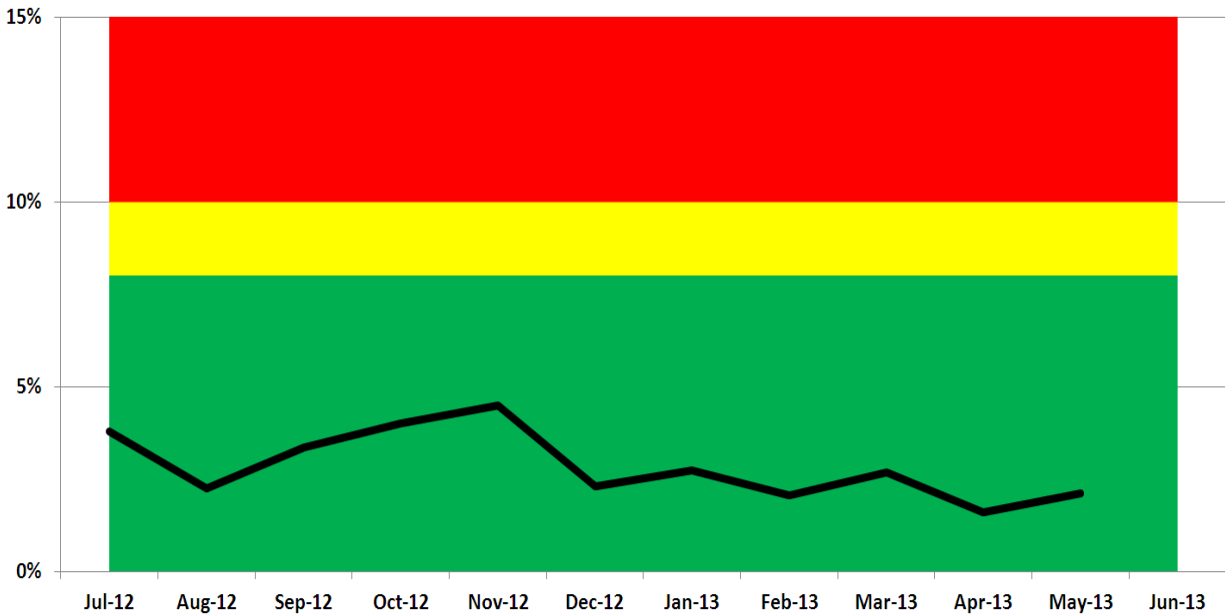
Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

Utilization this month was impacted due to a small number of individuals spending many days in jail. This data element can be significantly affected when one or two individuals are incarcerated. Typically, a single person incarcerated many days versus several individuals incarcerated only a few days cannot be determined from this data alone.

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, the target for this measure will be decreased to 0.250 days. The target is currently being met.

**Percent of Case Management consumers with
a Psychiatric Inpatient Admission within the past month
Target (10%) or less**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	5	4	8	12	15	9	12	10	14	9	11	0
Denominator	132	179	238	300	334	393	441	483	525	566	518	0
Rate	3.8%	2.2%	3.4%	4.0%	4.5%	2.3%	2.7%	2.1%	2.7%	1.6%	2.1%	#N/A
Quarterly Rate	3.1%			3.5%			2.5%			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of CM consumers with a Psychiatric Inpatient Admission within the past month.

Measure explanation: The percent of consumers in CM services for over thirty days that were admitted to a psychiatric hospital during the month.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers enrolled 30+ days and who were admitted to a Psychiatric Inpatient hospital during the month.

Denominator: Number of consumers enrolled on the last day of the month MINUS the number of enrollments during the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2013 Analysis

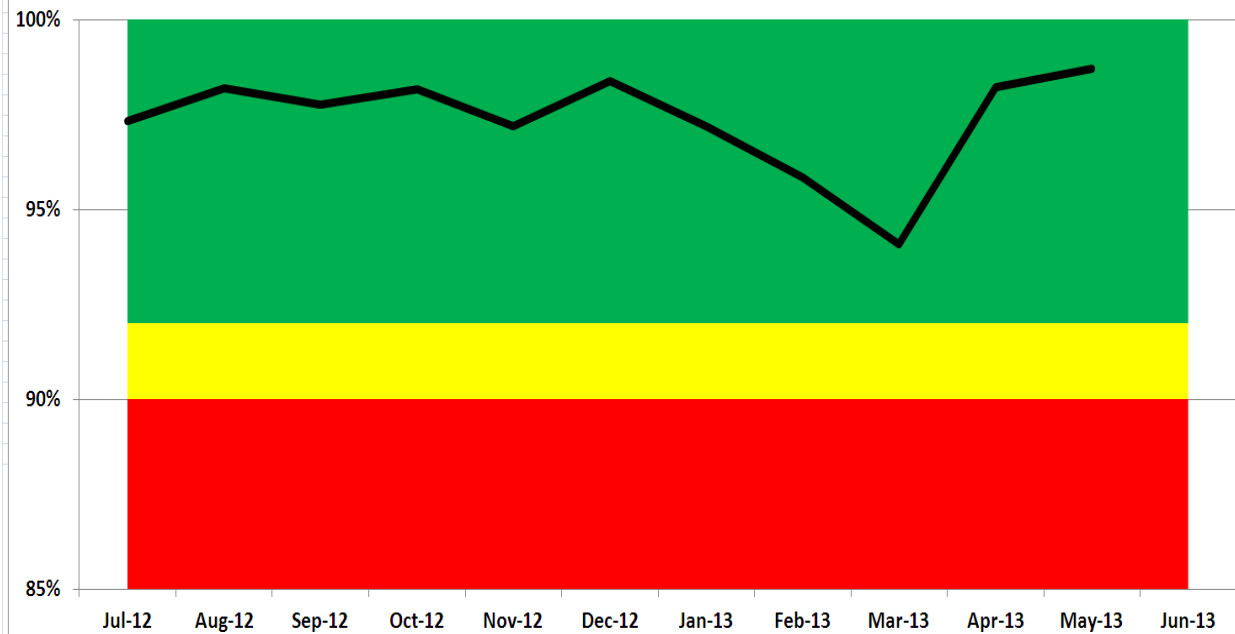
Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

The number of consumers with a psychiatric admission increased in March, however, due to a disproportionate increase in the numbers served, the percentage remained consistently low.

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, the target for this measure will be decreased to 5%. Target currently being met.

**Percent of Case Management consumers housed
(non homeless) within the past month
Target (90%) or more**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	183	219	263	268	414	428	487	529	574	604	535	0
Denominator	188	223	269	273	426	435	501	552	610	615	542	0
Rate	97.3%	98.2%	97.8%	98.2%	97.2%	98.4%	97.2%	95.8%	94.1%	98.2%	98.7%	#N/A
Quarterly Rate	97.8%			97.9%			95.6%			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of CM consumers housed (non-homeless) within the past month.

Measure explanation: The percent of consumers in CM services on the last day of the month that were not homeless.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers that were not homeless (on the street or in a shelter) on the last day of the month.	Denominator: Number of consumers enrolled on the last day of the month.
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COMMENTS AND/OR ANALYSIS PER QUARTER

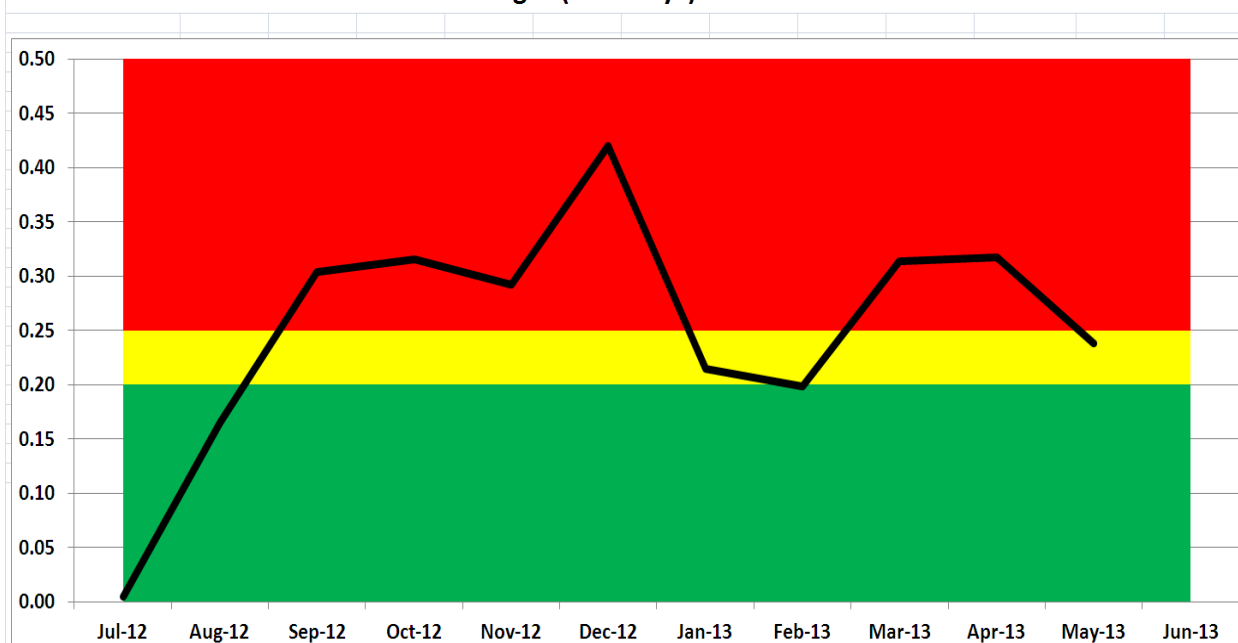
April-June 2013 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

Although data shows consistently high percentages throughout the quarter, Coalition meetings focused on resources available for individuals without income or with limited income. Target currently being met.

**Average # of jail/prison days utilized
(per enrolled Case Management consumer)
Target (0.25 days) or less**



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Numerator	1	43	99	126	133	215	123	121	201	208	143	0
Denominator	222	261	326	399	456	512	574	609	641	656	602	0
Rate	0.005	0.165	0.304	0.316	0.292	0.420	0.214	0.199	0.314	0.317	0.238	#N/A
Quarterly Rate	0.390			0.842			0.609			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: Average number of jail/prison days utilized per enrolled consumer.

Measure explanation: The average number of days consumers (who have been in CM services for over thirty days) spent in jail/prison during the month.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of jail days utilized for consumers in CM services 30+ days.

Denominator: Number of discharges during the month PLUS the number of consumers enrolled on the last day of the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

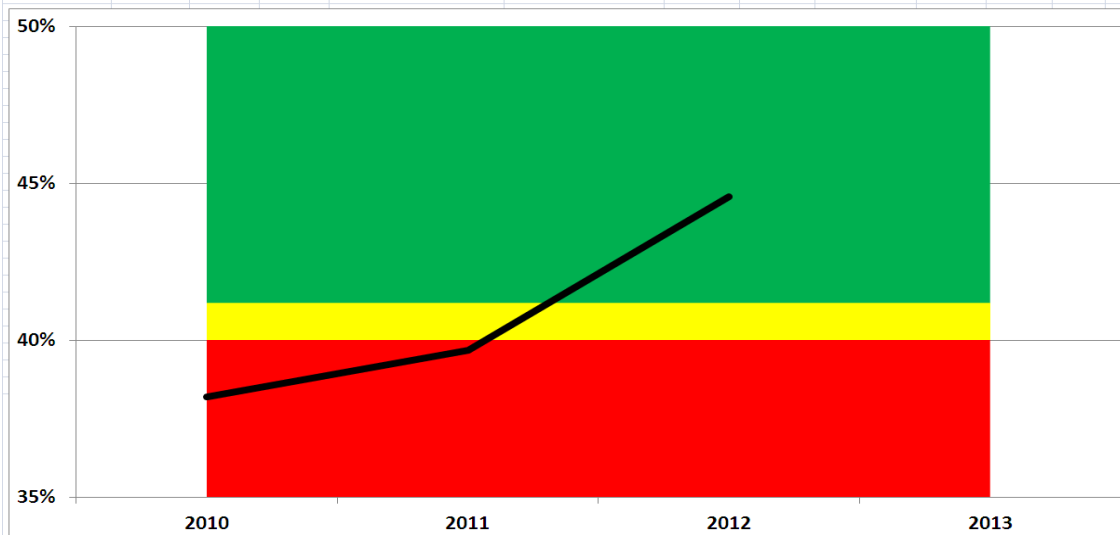
April-June 2013 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2013 Analysis

Case Management providers attributed the increase to a small number of individuals with longer incarcerations.

**Percent of adult AD consumers who abstain from use or experience reduction
in use (while in treatment)
Target (40%)**



	2010	2011	2012	2013
Numerator	11017	9782	10457	0
Denominator	28853	24656	23455	0
Rate	38.2%	39.7%	44.6%	#N/A

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage of adults served in community-based treatment who experience a reduction in alcohol and/or other substance use while in treatment.

Measure explanation: MICP Authorizations are used where the MICP had Adult Addictive Diseases selected as the Primary Diagnostic Category. The most recent values in the "Frequency of Use" fields are compared to the "Frequency of Use" values reported on the first available MICP in the episode of care. The data represents the number of episodes where a follow-up assessment (ongoing or discharge request) occurred during the report period compared to the initial assessment (registration or new episode request).

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The total number of "discharged" episodes, during the report period, showing a reduction in use or abstinence from alcohol or other substances compared to the beginning of the episode.

Denominator: Total number of "discharged" episodes during the report period. (Numbers of episodes does not necessarily indicate unduplicated consumers as an individual may have more than one episode during the report period.)

COMMENTS AND/OR ANALYSIS PER YEAR

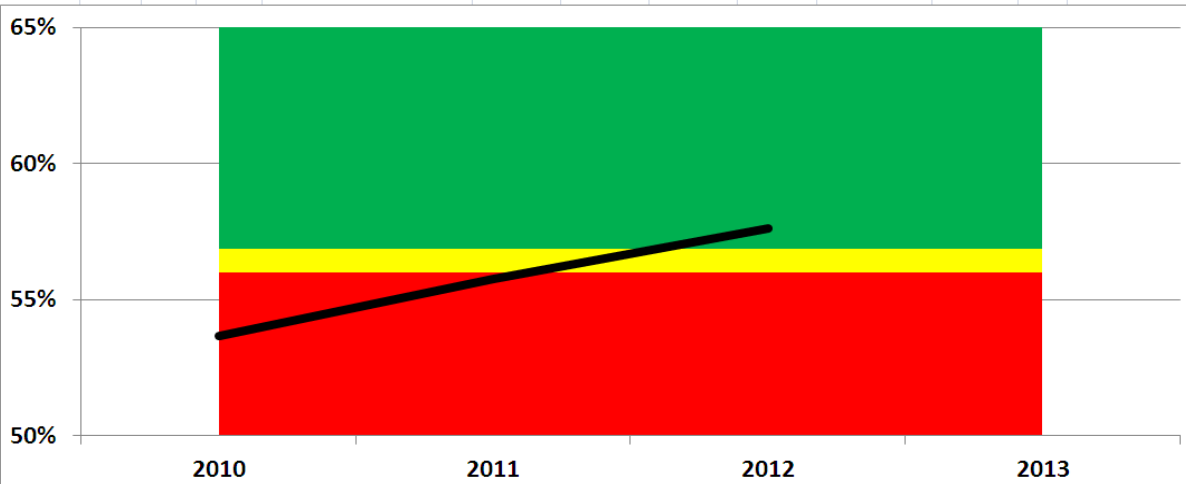
Annually 2013

At the time of this report, data was not available. Providers have 90 days to report encounters, making it inappropriate to report partial information at this time. In addition, the Division of Addictive Diseases has reviewed and determined that this KPI, although a NOM for the block grant, the measure fails to provide quality improvement significance as it relates to providers and services. We have proposed new KPI's that focus on access and retention which are more critical quality issues for our current system. This KPI will be replaced with; percentage of adult clients active in treatment 90 days after beginning non-crisis stabilization services.

Annually 2012

AD staff noticed a significant increase in 2012 of this measure. Potential reasons for the increase are; increase in provider reporting compliance of admission/discharge information, increase in individuals self-reporting a reduction in use while in treatment services.

**Percent of youth AD consumers who abstain from use or experience
reduction in use while in treatment
Target 56%**



	2010	2011	2012	2013
Numerator	716	595	329	0
Denominator	1334	1067	571	0
Rate	53.7%	55.8%	57.6%	#N/A

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage of youth (up to age 18) served in community-based treatment who experience a reduction in alcohol and/or other substance use while in treatment.

Measure explanation: MICP Authorizations are used where the MICP had C&A Addictive Diseases selected as the Primary Diagnostic Category. The most recent values in the "Frequency of Use" fields are compared to the "Frequency of Use" values reported on the first available MICP in the episode of care. The data represents the number of episodes where a follow-up assessment (ongoing or discharge request) occurred during the report period compared to the initial assessment (registration or new episode request).

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The total number of "discharged" episodes, during the report period, showing a reduction in use or abstinence from alcohol or other substances compared to the beginning of the episode.

Denominator: Total number of "discharged" episodes during the report period. (Numbers of episodes does not necessarily indicate unduplicated consumers as an individual may have more than one episode during the report period.)

COMMENTS AND/OR ANALYSIS PER YEAR

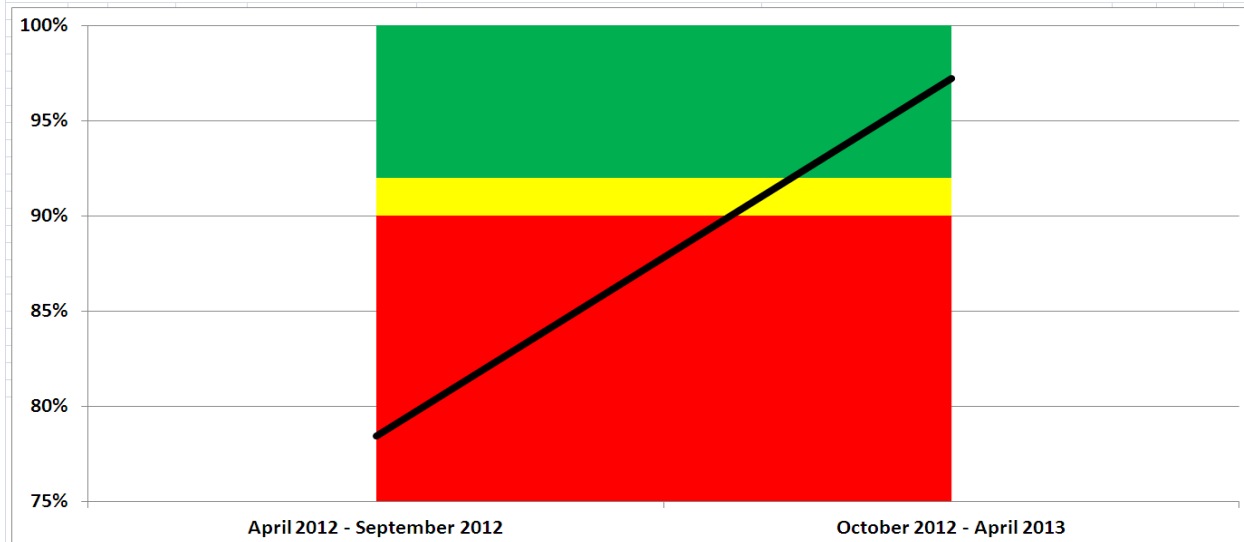
Annually 2013

At the time of this report, data was not available. Providers have 90 days to report encounters, making it inappropriate to report partial information at this time. In addition, the Division of Addictive Diseases has reviewed and determined that this KPI, although a NOM for the block grant, fails to provide quality improvement significance as it relates to providers and services. We have proposed new KPI's that focus on access and retention which are more critical quality issues for our current system. This KPI will be replaced with; percentage of clients discharged from crisis or detoxification programs who receive follow-up behavioral health services within 14 days.

Annually 2012

In 2012, AD staff noticed a slight increase in this measure as compared to 2011. The percent reported demonstrated an acceptable level of substance reduction while in treatment services which indicated that consumers are working towards recovery while engaged with provider.

Percent of individuals meeting community settlement agreement criteria who are enrolled in settlement funded services who state they are satisfied with the services they are receiving
Target 90% or greater



	April 2012 - September 2012	October 2012 - April 2013
Numerator	40	35
Denominator	51	36
Rate	78%	97%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of positive responses from individuals interviewed as part of the Quality Management ADA Audits who are asked if they are satisfied with services they are receiving.

Measure explanation: As part of the ADA Quality Management Audits, individuals were asked during an in person interview: "Are you satisfied with the services you are receiving?" From April 2012 to February 2013, individuals were asked to rate their satisfaction on a 5 point Likert scale. From March 2013 to current, individuals were asked to answer with a Yes or No.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: From April 2012 to February 2013, the number of responses of 4 or 5 on the Likert scale. In March 2013, the numerator became the number of Yes responses.

Denominator: Total number of responses to the question- "Are you satisfied with the services you are receiving?"

COMMENTS AND/OR ANALYSIS PER TIME PERIOD

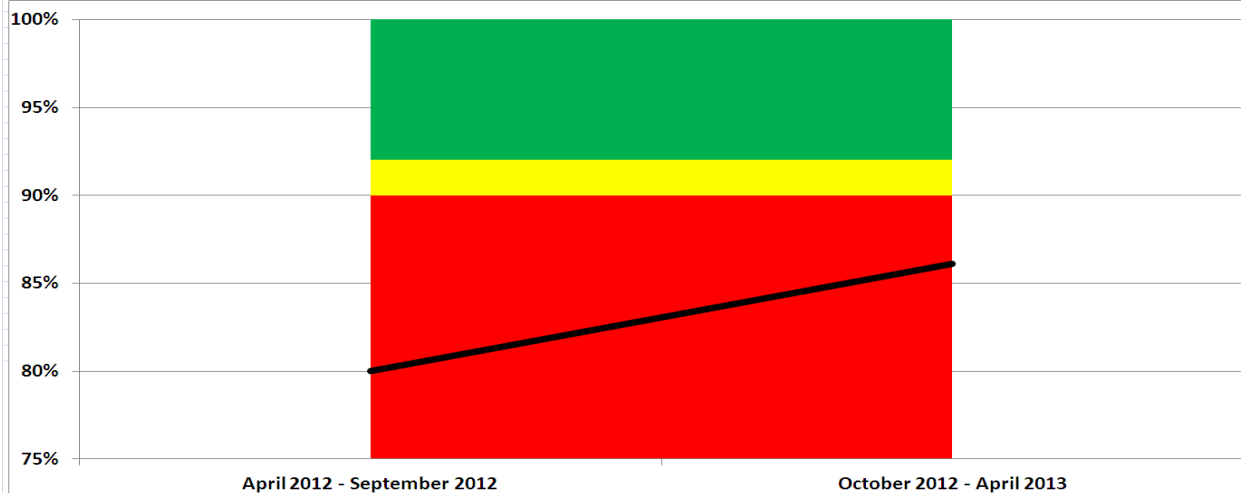
October 2012-April 2013 Analysis

ADA services have been in place for a longer period of time and providers have been improving their quality of service via agency specific PI indicators. It is hypothesized that these quality improvement processes may have impacted individuals' satisfaction with services.

April 2012-September 2012 Analysis

Many providers were still in the start up phase of service provision and many were in a learning curve regarding the state's standards and requirements during this time period. This may have impacted individuals' satisfaction with services.

**Percent of individuals meeting community settlement agreement criteria
who are enrolled in settlement funded services who feel their quality of life
has improved as a result of receiving services
Target 90% or greater**



	April 2012 - September 2012	October 2012 - April 2013
Numerator	40	31
Denominator	50	36
Rate	80%	86%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of positive responses from individuals interviewed as part of the Quality Management ADA Audits who are asked if their quality of life has improved since being enrolled in a specific ADA service.

Measure explanation: As part of the ADA Quality Management Audits, individuals were asked during an in person interview: "Has your quality of life improved with the service you are receiving?" From April 2012 to February 2013, individuals were asked to rate their satisfaction on a 5 point Likert scale. From March 2013 to current, individuals were asked to answer with a Yes or No.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: From April 2012 to February 2013, the number of responses of 4 or 5 on the Likert scale. In March 2013, the numerator became the number of Yes responses.

Denominator: Total number of responses to the question- "Has your quality of life improved with the service you are receiving?"

COMMENTS AND/OR ANALYSIS PER TIME PERIOD

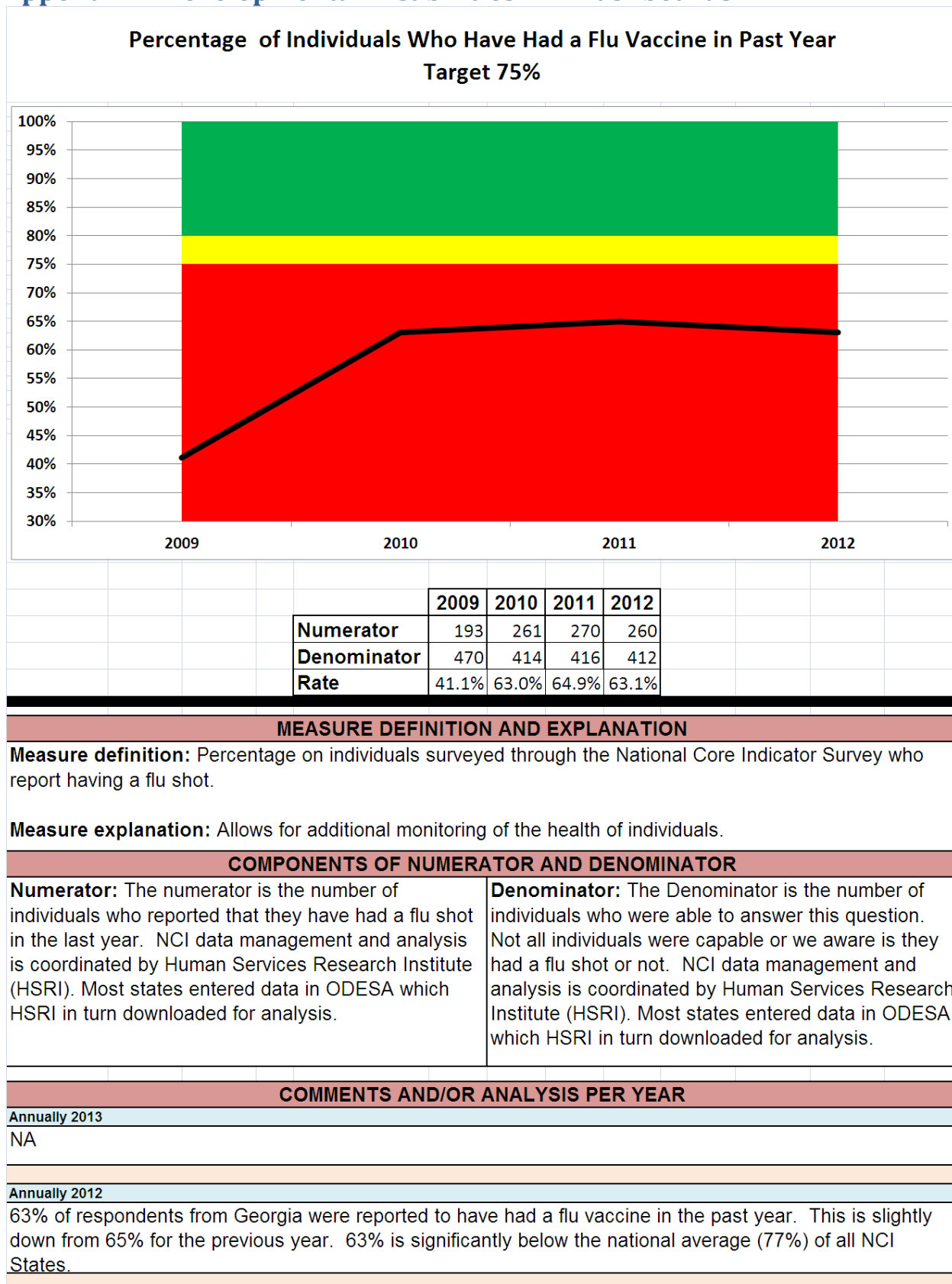
October 2012-April 2013 Analysis

While there is an upward trend towards overall improvement in quality of life, the benchmark may be difficult to reach due to the nature of SPMI and its impact on the individual. Because individuals are continuously enrolled in services, there is a subset of individuals interviewed who may not have been enrolled in services for a sufficient amount of time to realize the impact on their quality of life. The trend should continue to improve as providers continue to improve their quality of service.

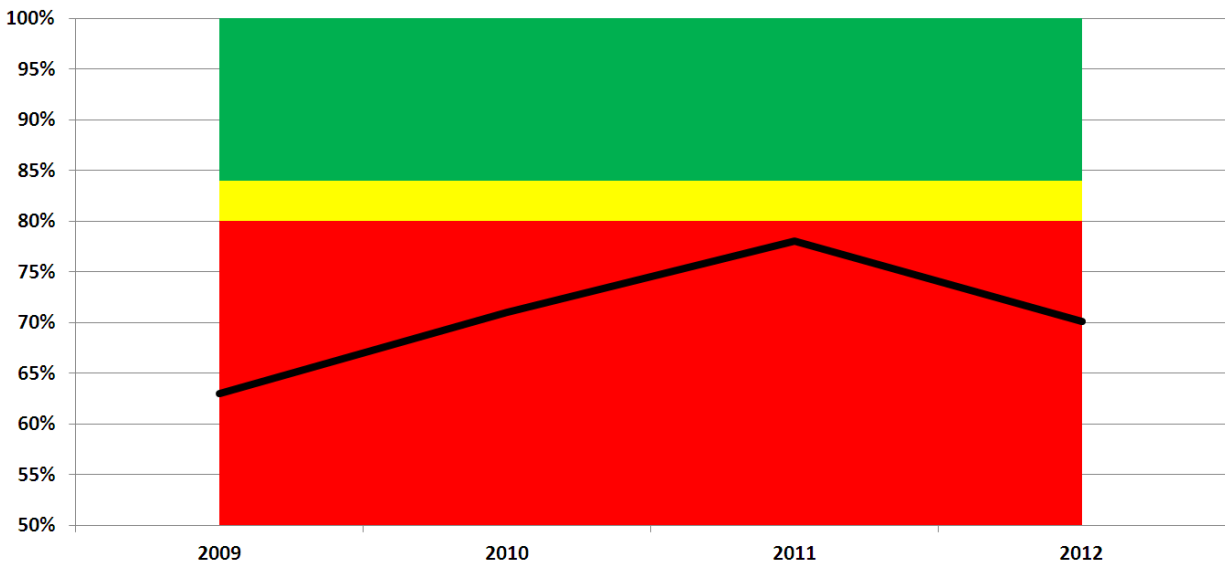
April 2012-September 2012 Analysis

ADA services had not been in place for a long period of time and it has been hypothesized that there was insufficient time for individuals to realize the impact on their quality of life.

Appendix H Developmental Disabilities KPI Dashboards



Percentage of Individuals Who Have Had a Dental Examine in Past Year
Target 80%



	2009	2010	2011	2012
Numerator	301	306	326	312
Denominator	478	431	418	445
Rate	63.0%	71.0%	78.0%	70.1%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage on individuals surveyed through the National Core Indicator Survey who report having a dental exam.

Measure explanation: Allows for additional monitoring of the health of individuals.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they have had a dental examination in the last year. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered data in ODESA which HSRI in turn downloaded for analysis.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were aware if they had a dental exam or not. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered data in ODESA which HSRI in turn downloaded for analysis.

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2013

NA

70% of respondents reported having a dental exam in the past year. This is down significant from 78% the previous year. 70% is also significantly lower that the national average (80%) for all other NCI States. This KPI has been given Departmental priority and solutions to improve this KPI are being reviewed.

Percentage of Individuals Who Have Had an Annual Physical in Past Year
Target 92%



	2009	2010	2011	2012
Numerator	412	414	373	466
Denominator	479	465	451	518
Rate	86%	89%	83%	90%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage on individuals surveyed through the National Core Indicator Survey who report having a physical exam.

Measure explanation: Allows for additional monitoring of the health of individuals.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they have had an annual physical examination in the last year. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered data in ODESA which HSRI in turn downloaded for analysis.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or we aware is they had a physical exam or not. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered data in ODESA which HSRI in turn downloaded for analysis.

COMMENTS AND/OR ANALYSIS PER QUARTER

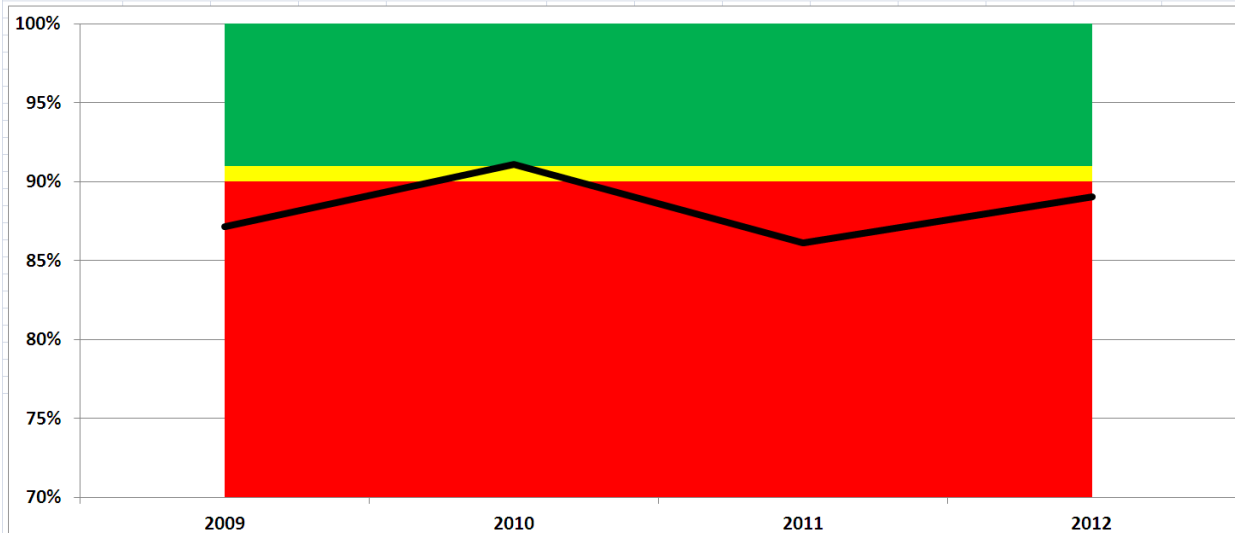
Annually 2013

NA

Annually 2012

90% of respondents reported having had a physical exam in this past year. This is slightly down from the previous year which as reported at 91%. 90% is in line with the national average (90%) for all other NCI States.

Percentage of Individuals Who Feel Safe in Their Home
Target 90%



	2009	2010	2011	2012
Numerator	264	297	291	342
Denominator	303	326	338	384
Rate	87%	91%	86%	89%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage on individuals surveyed through the National Core Indicator Survey who report feeling safe in their residential environment.

Measure explanation: Allows for additional monitoring of the safety of individuals

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they either feel safe in their home or never feel afraid in their home. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered data in ODESA which HSRI in turn downloaded for analysis.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were willing to answer this question. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered data in ODESA which HSRI in turn

COMMENTS AND/OR ANALYSIS PER QUARTER

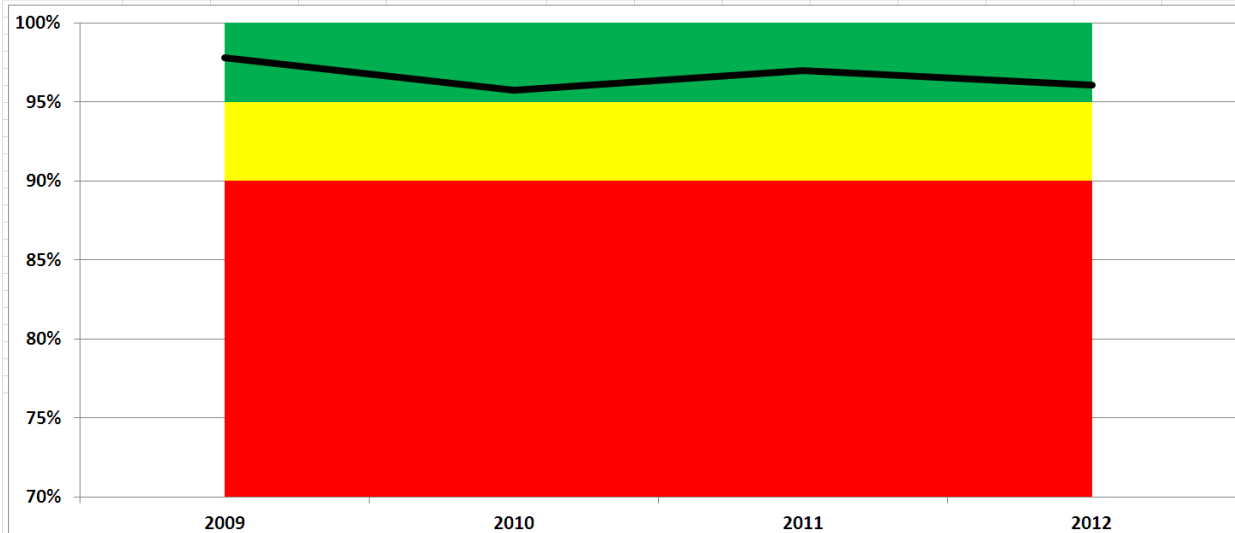
Annually 2013

NA

Annually 2012

89% of respondents reported they never feel scared at home. This is an improvement from the previous year which was reported at 86%. 89% is in line with the national average (82%) for all other NCI States.

Percentage of Individuals Who Report They are Treated with Dignity and Respect
Target 90%



	2009	2010	2011	2012
Numerator	133	157	194	170
Denominator	136	164	200	177
Rate	98%	96%	97%	96%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage on individuals surveyed through the National Core Indicator Survey who report staff and family treat them with respect.

Measure explanation: Allows for additional monitoring of the safety of individuals.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that their staff treat them with dignity and respect. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered data in ODESA which HSRI in turn downloaded for analysis.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were willing to answer this question. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered data in ODESA which HSRI in turn

COMMENTS AND/OR ANALYSIS PER QUARTER

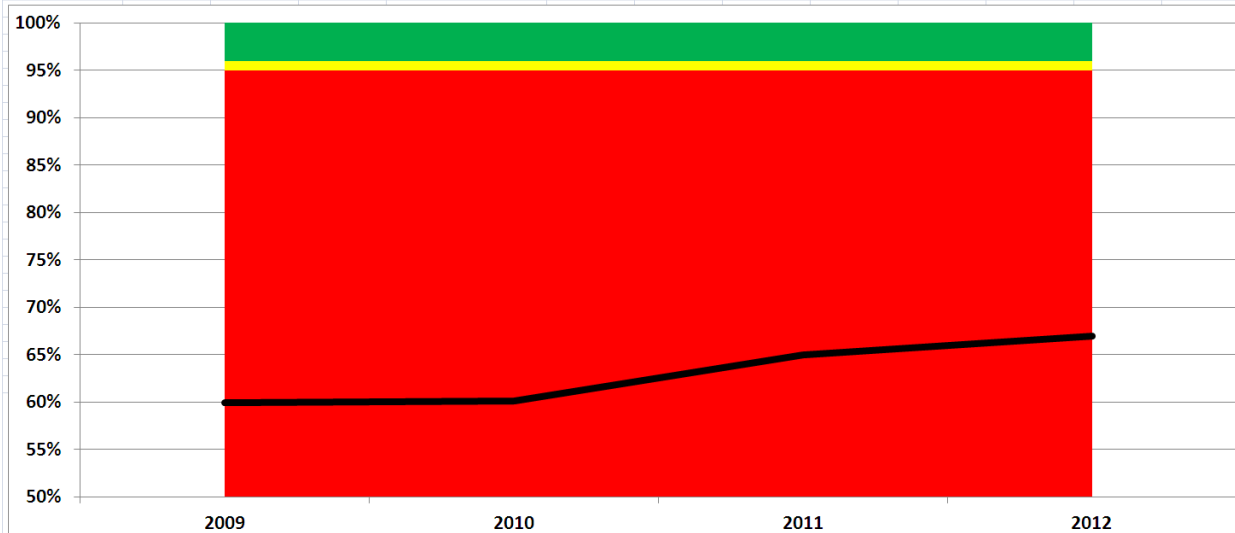
Annually 2013

NA

Annually 2012

96% of respondents reported that they are treated with dignity and respect. This is slightly down from the previous year when 97% reported they felt that they were treated with dignity and respect. 96% is in line with the national average (94%) of all other NCI States.

Percentage of Individuals Who Report They have a Choice of Supports and Services
Target 95%



	2009	2010	2011	2012
Numerator	281	265	297	349
Denominator	469	441	457	521
Rate	60%	60%	65%	67%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Individuals report that they have choice in the supports they receive.

Measure explanation: Division of DD strives to support individuals to move choice in all supports and services.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that their staff treat them with dignity and respect. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered in ODESA which HSRI in turn downloaded for analysis.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were willing to answer this question. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered in ODESA which HSRI in turn downloaded for analysis.

COMMENTS AND/OR ANALYSIS PER QUARTER

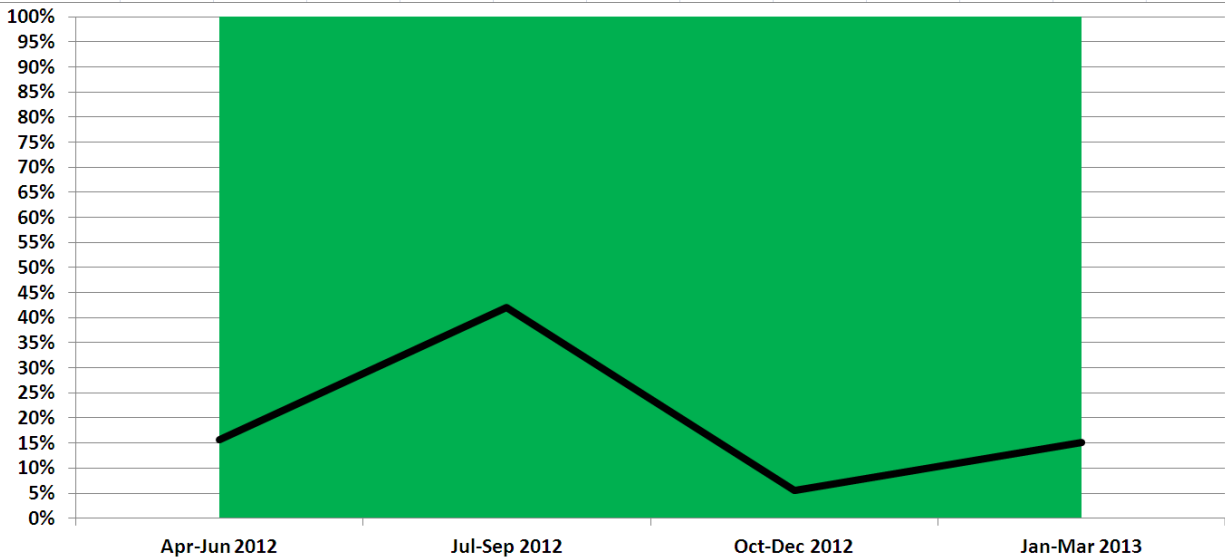
Annually 2013

NA

Annually 2012

67% of respondents reported that they have a choice of supports and services which is 2% improvement from the previous year. 67% is significantly above the national average (54%) of all other NCI States.

Percentage of Crisis Incidents that Resulted in Intensive In-Home Supports



	Apr-Jun 2012	Jul-Sep 2012	Oct-Dec 2012	Jan-Mar 2013
Numerator	34	115	17	35
Denominator	216	274	307	231
Rate	15.7%	42.0%	5.5%	15.2%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage of crisis incidents that could warrant additional in-home supports for the individual or family in crisis.

Measure explanation: Most crisis episodes can be sufficiently addressed by a Mobile Crisis Team at the time of the crisis. Some crisis episodes, however, may need additional supports or training for the individual or family that will hopefully lessen or eliminate the chance of such a crisis happening again. These supports or trainings may be provided in the person's home for up to 24 hours a day and 7 days a week.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of crisis episodes statewide that resulted in the need for additional intensive in-home supports.

Denominator: Total number of crisis episodes statewide.

COMMENTS AND/OR ANALYSIS PER QUARTER

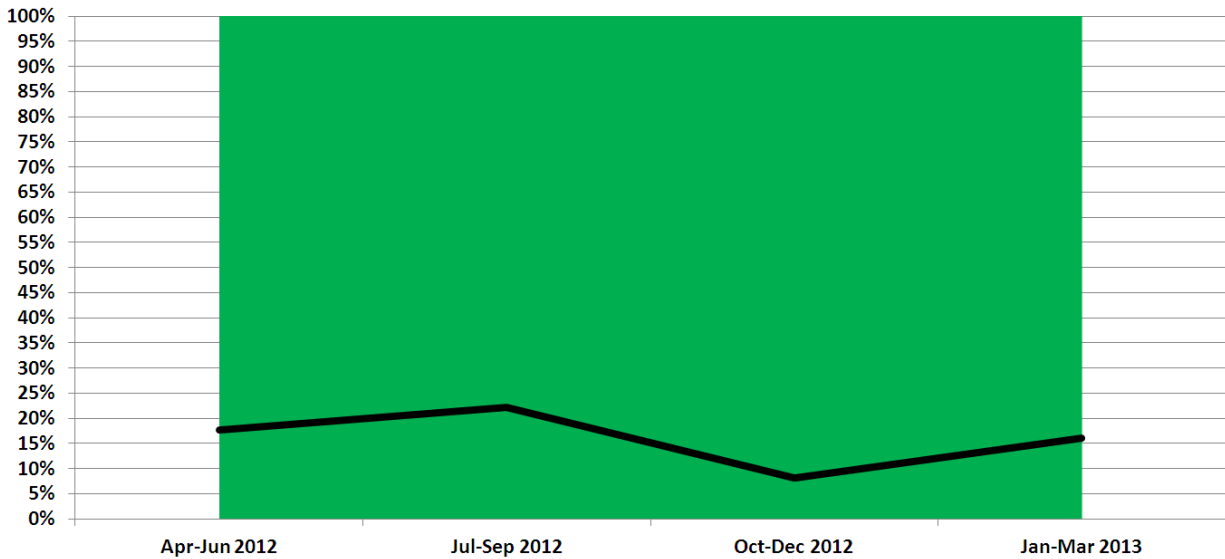
April-June 2013 Analysis

NA

January-March 2013 Analysis

The DD Crisis Response System was implemented in June 2011. It is new crisis system for Georgia, and goals have not been set at this time for the intensive in-home supports. It is the hope of the Department that most crisis episodes can be resolved with the least amount interruption in the individual's life. This quarter's result of 15% is in line with data from 3rd quarter last year which was 15%.

Percentage of Crisis Incidents that Resulted in Placement of the Individual in a Crisis Support Home



	Apr-Jun 2012	Jul-Sep 2012	Oct-Dec 2012	Jan-Mar 2013
Numerator	38	61	25	37
Denominator	216	274	307	231
Rate	18%	22%	8%	16%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage of crisis incidents that could warrant placement in a crisis support home while the crisis was addressed.

Measure explanation: Most crisis episodes can be sufficiently addressed by a Mobile Crisis Team at the time of the crisis. Some crisis episodes, however, may need additional supports or training for the individual or family that will hopefully lessen or eliminate the chance of such a crisis happening again. From time to time it may be in the best interest of the individual and family that these supports and trainings be provided out of the individuals home and in a crisis support home. Placement in a crisis home should be the option of last resort for dealing with a crisis episode.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of crisis episodes statewide that resulted in the need for an individual to be removed from their home and place in a crisis support home.

Denominator: Total number of crisis episodes statewide.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2013 Analysis

NA

January-March 2013 Analysis

The DD Crisis Response System was implemented in June 2011. It is a new crisis system for Georgia, and goals have not been set at this time for the intensive out of home (crisis home) supports. It is the hope of the Department that most crisis episodes can be resolved with the least amount interruption in the individual's life. This quarter's result of 16% is up slightly from the time last year (14%). Many placements in a crisis home are the result of an individual being in crisis and the lack of appropriate emergency respite services in the community. The Department will be addressing this issue over the next few months.

Appendix I Cognitive Therapy – Dr. Aaron T Beck

History of the Cognitive Therapy

Aaron T. Beck, MD developed Cognitive Therapy in the 1960's as an alternative approach to the psychoanalytical process. Dr Beck originally developed this structured, short-term, present-oriented psychotherapy for depression, directed towards solving current problems and modifying dysfunctional thinking and behavior. Dr. Beck and others have successfully adapted this therapy to a diverse set of psychiatric disorders and populations. Dr. Beck and his team are currently emphasizing the treatment of schizophrenia in their work, emphasizing the synergy between recovery-oriented principles and cognitive therapy strategies. Cognitive therapy is being used across a very wide range of presenting problems and populations all over the world. Cognitive Therapy has the most extensive empirical support for its effectiveness among all the existing psychotherapeutic approaches.

Brief Overview of Cognitive Therapy

Cognitive Therapy is based on the cognitive model, which proposes that dysfunctional (inaccurate or unhelpful) thinking is common to all psychological disturbances. This model states it is not the situations in our lives that shape how we feel, but rather our perception of those situations that influences our emotions and behaviors. Changes in our thinking can make a difference in how we feel and act in relation to those situations. Enduring improvement results from changes in an individual's underlying dysfunctional beliefs. Treatment is based on a cognitive conceptualization of or understanding of the individual's thoughts and beliefs. The cognitive therapist seeks to collaboratively produce change in the client's thinking and belief system, with the aim of bringing about enduring emotional and behavioral change.

CT-R Training Program at a Glance

Phase 1: Workshops

- **Outpatient:** 5-day training (1 week)
 - **First day only (6 hours):** key support staff (job coaches, peers, team nurses and team psychiatrist)
 - **All 5 days (30 hours):** Clinicians and team leaders
- Workshops will be given twice so ACT/CST teams can divide to ensure consumer coverage during trainings.
- **Inpatient:** 4-day training (1 week)
 - Focus: understanding and interventions to promote discharge and community reintegration.
 - First day only (6 hours): all staff involved in treatment: HSTs, nurses and peers
 - All four days (24hours): Clinicians, RAR coordinator, advocate, social workers and treatment team facilitators.
- **Supervisors (without therapy caseloads):** 1 day, 6 hours
 - Basic CT-R tutorial to facilitate supervisee's work

- Systems to expand and maintain CT-R in the agency
- Managing the review agencies and CT-R

Phase 2: Consultation

- 6 months of weekly ongoing consultation to support trainees in applying CT-R in their specific roles
 - Case conceptualization
 - Intervention planning
 - Group feedback from instructors and trainees
 - Weekly review of trainee's audio from sessions

Phase 2: Recording and Ratings

- Each outpatient clinician trainee selects 5 individuals
 - **Audio:** record all sessions
 - **3-month:** detailed feedback given on the Cognitive Therapy Rating Scale (CTRS)
 - **6-month:** competency determination via CTRS

Phase 2: Supervisors

- Monthly meetings:
 - Track progress of trainees
 - Problem-solve issues that arise
 - Supporting topics
 - Engagement
 - Effective goal-setting and break down
 - How to think about hallucinations and delusions
 - Extend CT-R within the organization

Phase 3: Sustainability

- Local Champions (12 months, 1 hour a week)
 - Skilled CT-R trainees selected to represent the subareas of the region
 - Further instruction given to increase skill level
 - Local experts created across the region
 - Champs guide other trainees in the area and provide supervision in time

Phase 3: Sustainability

- Center of Excellence
 - Experts trained and practicing CT-R
 - Expand CT-R penetration and spread
 - Creation of CT-R Online Community
 - Functions: Further training of agencies, support of CT-R trainees and boosting trainings

Appendix J Suicide Prevention

According to the Centers for Disease Control and Prevention (CDC) suicide is the 10th leading cause of death in Georgia and the United States. The number of suicide deaths exceeds the number of homicide deaths by nearly 40% yearly. In 2010, the last year data has been publicly reported through the National Violent Death Reporting System, Georgia had 1,131 deaths with a death rate of 11.66 per 100,000 citizens. The most common method in completed suicides was use of a firearm (56%); the second most common method was hanging, strangulation or suffocation (16 %) followed by poisoning (11%). White males over 45 years of age have the highest number of suicides followed by white females. Numbers and rates of suicide increase with age until age 75 when the rate declines slightly. The most prevalent reported circumstances of death were current depressed mood (40%) and current mental health problem (30%).

Individuals with mental health and/or health problems are at markedly higher risk to die by suicide. Mental Health problems that relate to a higher suicide rate include severe depression, other psychiatric disorders and drug/alcohol misuse. Since behavioral health treatment is proven to reduce suicide deaths of those in care, identification of suicidal risk, access to care, intervention, and monitoring have the potential to reduce the incidence of suicides. The DBHDD Suicide Prevention Program works to do the above through its prevention, intervention and postvention activities.

Once a person has reached out for assistance it is important to provide safety and evidence-based treatment. The Suicide Prevention Program has focused its efforts within the DBHDD provider network on understanding the system level circumstances of the suicide deaths reported to the Department as incidents. Level 1 of the SPEBP Initiative involves:

- Using the CDC's Self-Directed Violence Surveillance: Uniform Definitions and Data Elements to address lack of common definitions in reporting suicidal behavior,
- Using The Columbia Suicide Severity Rating Scale (C-SSRS) to address lack of an effective process to identify people at risk of suicide,
- Using Drs. Barbara Stanley and Greg Brown's Safety Planning and Follow-up Tool to address lack of immediate interventions for those at risk of suicide but who don't need to be hospitalized, and
- Providing training to DBHDD provider leadership regarding current best practices in Assessing and Managing Suicide Risk (with a focus on basic competencies).

Taken together, the elements above form DBHDDs SPEBP Initiative called A.I.M. (Assessment, Intervention, and Monitoring). The intended outcome is; identification, brief intervention and monitoring for consumers who are at high risk of suicide with the goal of helping them become securely situated in services and more empowered to act in their own self-interest.